Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 17 ^{Year}010 1:59AM Catherine B. Graber Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 F Days Hours Months October 26, 1924 Director 218-22-7856 85 Maryland Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits Balto. Nottingham 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4300 Cardwell Avenue 21236 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes No
If Yes, Give
Year or Dates. Black, White, etc. White 1 Never Married 2 Married þ 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 3X Widowed 4 ☐ Divorced Specify: Completed raber, Catherine 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) . Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louis Batchelor Catherine Forsythe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Jeffrey</u> C. Graber Son 9112 Bowline Road Perry Hall, Md. 21128 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Bayview 9-20,2010 Balto. Md. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Severe Pulmonan intenous /ledical Due to (or as a consequence of): aminer Hea Uncurren Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Pleural ffusion unkurn that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death
Pregnant at time of death in the past 12 months? Month the a Day Year P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, cate has been sig page 2 should to 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes Anascerca 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Arial Febrillation this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director, After this certifics completed filled in by the funeral director, to 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, de date and place, and due to the cause(s) and mainler as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

6701 North Charles Street Baltimore Maryland 21204

GBML

SEP 21

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John C. Germanalt MD

JC Greenanatt, MD

31. Date filed (Month, Day, Year)

A face

D00 60248

September 17, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Catherine George September 18, 2010 5:40 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice Social Security Number **Funeral** 7. Age (In yrs. last birthday) 75 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 218-32-9172 1 □ M 2**XX**F Days Hours July 10, Year 35 Mary land Director Yrs. Usual Residence of Decedent show filed within 72 hours after death with the Maryland all Hygiene.
d other than "natural", or items 23a or 28a-f show 10a. State 10b. County event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 ☐ No N/A Baltimore Maryland 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21211 USA 3310 Paine Street 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Yes 2X No Yes, Give 3altimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: 3 Divorced 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Unknown College (1-4 or 5+) Clerk Optical Company Be permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any liuly or other traumatic event once, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Margaret Slonaker Pierce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 3310 Paine Street, Baltimore, Maryland 21211 Robert L. George, Jr. Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Crestlawn Memorial 9/23/2010 Marriottsville, Maryland 21. Signature of uneral Service Licer 22. Name and Address of Facility Burgee Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Stage Lung disease Physician/ -11 disease or condition resulting in death) Medical Examiner ans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year ed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ConceR STYOKE 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Hospital: 2 No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Charles St. Balto, Md 2120x

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 18°, 20°°°0 sept. 11:17a MArgaret Louise Gast Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Gilchrist Center Towson Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 ☐ M 2 ☐**X** (Month, Day, Months Days Hours Min. 212-48-7066 Yrs. Director 19,1946 Dec. Usual Residence of Decedent "natural", or items 23a or 28a-f show sdical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Baltimore Middle River 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21220 1532 Chilworth Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2X Married 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical J ence. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Franklin Square Certified Nursing Asst. 11+h 17. Father's Name (First, Middle, Last) いっとつい 18. Mother's Name (First, Middle, Maiden Surname) Josephine Wise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1532 Chilworth Avenue Balto. MD 21220 John Gast /husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burjal 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) 9/20/10 Baltimore MD Bayview Crematory 21. Signs turn Funeral Vice Licensee 22. Name and Address of Facility 300 Connelly Funeral 22. Name and Address of Facility Mace Home Ave Balto MD of Essex 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line metristic Onset and Death Immediate Cause (Final Hysician Medical resulting in death) Due to (or as a consequence of): Examiner Service tietly list convittions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year cate has been signed by the a page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? this certificate 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 - Nursing Home 5 - Residence 6 Other (Specify) 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier License number tember 16 2010

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 0 Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Lorien-Mays Chapel Timonium . Social Security Number 6. Sex Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Aug 28, Year) 931 Months 223-34-3291 1 M 2 X F 79 Virginia Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Baltimore Timonium 1 🗌 Yes 2 🗆 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 U.S.A. 232 Deep Dale Drive Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 XMarried ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Morris Madeline Norene Brinkley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Charles P. Garrison, Jr.-husband 232 Deep Dale Dr., Timonium, MD 21093 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State Hilltop Serv Corp 9/21/10 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau William 1050 York Rd., MD Towson, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to for as a consequence off Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 Oo Month Day Year Other (specify) Pregnant at time of death signed by the a d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably Division of Vital Records, 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has bage 2 s autonsy perform death? 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 XX Hospital Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Manner of Death in 24 hours after upage... he Funeral Director: After the noteted filled in by the funeral funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 5 Pending 2 Accident
3 Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and title of certifier

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 05:35PM DIANA HARTIN BONITA SEP Medical 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COLUMBIA HOWARD COUNTY HOWARD COUNTY GENERAL HOSPITAL If Under 1 Year I If Under 24 Hrs. Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign May 24, 1 M 2 F 82 Carrada T928 Director 161-24-5410 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Marvland Howard Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20794 **USA** 8310 Autumn Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Earl L. Shaw Ella M. Rutledge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Hartin, Son 6671 Athol Avenue Elkridge, Maryland 21075 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 09/20/10 Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility Cremation. Society 299 Frederick Road Of Maryland, Inc. Baltimore, Maryland 21228 roman 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ACUTE CEREBROVASCULAR ACCIDENT disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner COPD EXACERBATION Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ATRIAL FIBRILLATION attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autonsy performed Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physivithin 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) MD Mythilly SEP, 19, 2010 D0064760 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MYTHILY VANCHA 10710 CHARTER DRIVE, COLUMBIA

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 18, 9:50 PM Physician/ September 2010 Jefferson Davis Hood Sr. Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Howard Mt. Airy 2107 Long Corner Road 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days (Month Day, Year) Hours Min. 1 XM 2 □ F Mary Land 61 219-50-4364 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27: is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2X No Mt. Airy Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21771 2107 Long Corner Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Laborer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Dorothy R. Issac Jefferson Davis Hood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2107 Long Corner Road Mt. Airy, Maryland 21771 Alice L. Hood, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 09/24/10 Metro Crematory Inc. . Signature of Funeral Service Licence Thomas Gregor RANGABO TUNIETAL Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 Mmai 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final METASTATIC LUNG Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 2 🗌 No 26. Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death 28a, Date of injury Certificate: al or Attending P s after death. I Director: After t (Month, Day, Year) 5 Pending injury 1 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 □ 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

900 CATON AVE BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E.W. COLE

31. Date filed (Month, Day, Year)

		State of Maryland / [Depa	rtment of He	alth and I		0.0	1.0	00507
		1 _ State Registrar	Cert	ificate of De	eath		Reg. No.	0 1 0	29507
Physicia		1. Decedent's Name (First, Middle, Last) Mary Jane Hall				2. Date of Dea Month Septemb	Day	Year 2010	3. Time of Death 4:10 A M
Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Lo	ocation of Death			nty of Death	110.11
		Gilchrist Hospice Center		Towson			Ва	1timo:	re
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt			f Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	9. Birth	place (State or Foreign
Director		217-34-0470 /1	Yrs.	Month's Days	Hours Will.	April 2	6,1939	1	Maryland
d d		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or t oc:	ation					10d. Inside City Limits
ırylan ı-f sh ïed a	cto								1 ☐ Yes 2 🔯 No
ie Ma ir 28k notif	Dire	MD Baltimore Cat	cons	ville 10f. Zip Code			10a. Citizen o	of What Cou	intry?
/ith th	<u>ra</u>	1316 Middleford Road		21228			USA		,
ems r mu	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S.	13. W	as Decedent of Hisp Yes, specify Cuban,	anic Origin? (Sp	ecify Yes or No-		ace - Ameri	can Indian,
orit mine	by F	Armed Forces? 1 □ Never Married 2 ▼ Married 1 □ Yes 2 ▼ No	- 1			Rican, etc.)		lack, White,	_{etc.} White
JOS Jural" LExa	pe	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	Yes 2X No	Specity:		Spec	ity:	WIIICC
2 hou "nat	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	(Give kii	ent's Usual Occupation of work done duri		king	16b. Kind of	Business Ir	ndustry
TZ thin 7	녌	Elementary/Seconday (0-12) College (1-4 or 5+)		NOT use retired) maker			Own	Ноте	
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ary and M ond M s mar		19a. Informant's Name/Relationship (Type, Print) 19b	b. Mailing	Address (Street and	d Number or Rui	ral Route Number	; City or Town	, State, Zip	Code)
Baltimore, Maryland 21213-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		William Hall Husband 13	316 1	Middlefor	d Road;	Catonsv	ille,	MD 21	228
of He fiten		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 20b. Place o cemete	of Dispos	ition (Name of atory or other place)		Date	20c. Locatio	n - City or T	Town, State
Page ment ant: I			tic	Crematory		/2010	Glen H		
Ball permit Depart Import any inj		21. Signature of Funeral Service Licensee	22. F1	Name and Address uneral Hor	of Facility Steme of Ca	erling A atonsvil	s ht on 1e. In	Schwal	b Witzke
™		Janelle L. Jamenery	-1.16	630_Edmon	dson Ave	enue:_Ca	tonsvi	11e,	MD 21228
		23a. Per 1. Enter the disease, of complications that caused the death. No r shock, or heart failure. List only one cause on each line.			such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Deaths
Medical	3 9	reculting in death)		meek				- 1	Onset and Death
Examiner		Due to (or as a consequence	of):						1
	ner	Sequentially list conditions, if any, leading to immediate traces from Inderlying.	of):						
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e exec	Ê	resulting in death) Last	of):						
ate be	dic	d			<u> </u>				
66/ ertifice iding p	/We	IF FEMALE: 23c. If yes, outcome of pregnancy					234	Date of deli	ven/
Geath c death c he atten ed for us	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		Ectopic pregnancy Other (specify)				Month	Day Year
the de sy the ached	Physician/Me	g Unknown							
that the	by P	Part II. Other significant conditions contributing to death but not resulting	in the un	derlying cause giver	n in Part I.		_		the cause of death?
dS, quires en sig						1 2	Yes 2 □ No	> 3 □ Pro	obably 4 🗆 Unknown
Kecords, The law requires sate has been sig page 2 should b	Completed					24a. Was autop	sy	prior to c	opsy findings avallable ompletion of cause of
The The page	S					1 🗆 Yes	rmed? 2 No	death?	2 🗆 No
VITAI nysician: ils certific director,	Be	25. Was case referred to medical examiner?		Other	e of Death (Che				1/2/2/22
Of V og Phys ter this neral dir	2	1 Inpatient 2 I ER/Ou	utpatient Time of	28c. Injury a	4 ☐ Nursing H	lome 5 Resid			W (412/0160
ding th. After fune	Certificate:		injury	work?	es 2 🗌 No	20d. Describe II	ow injury occ	arred	
DIVISION tal or Attendii rs after death. af Director: Af ed in by the fu	ığı.	3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	arm, stre	et, factory, office				nber or Run	al Route Number,
UN talor safter al Dir	7	building, etc. (Specify)			//	City or Tow	n, State)		
Division of Vital Records, F.O. Box 68 /60 C. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/o	or investig	gation, in my opinion,	death occurred	at the time, date a	nd place, and	due to the c	ause(s) and manner stated.
To the within To the complete	-	29h Signature and title of certifier		29c. License n	umber		29d. Date sig		, Day, Year)
		10/1 Hothony /lily, "	N	020	207		Sept	col-	m/1, 2010
12		30. Name and address of person who completed cause of douth (Item 23a) WARGE COT	(Type, Pr	N. Chr	eles ST	X. Ba	lto.	md	21204
Sta Registra	te	31. Date filed (Nath Pay Year) 2010 31. Registrar's Signature	fa	Kal					

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 29508 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) $r^{\text{Day}}19,2010$ **Physician** September 1:00 P M Frances Louise Hittel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sykesville Carroll Transitions Health Care If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Nov. 27, 1919 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral Months Days Hours 1 □ M 2 1 F 217-07-8155 Maryland Director 90 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Marital Examinat rout be natified at once. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 ☐ Yes 2 No Funeral Director MD Carroll Eldersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21784 USA 5766 Oyster Bay Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black White etc. 1 Yes 2 If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married White 1 ☐ Yes 2 🖾 No Specify: Specify: Be Completed by 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roy Davidson Margaret Hahn ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara Cimbolo Daughter 1015 Falls Road; Parkton, MD 21120 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/22/2010 Baltimore National Baltimore, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke nature of Funeral Service Licenses Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue: Catonsville, MD not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or or plications that caused by death, shock, or heart failure. List of ly one cause on each line. Approximate Interval Between Onset and Death therosclerob Immediate Cause (Final **Physician** 2050 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner fecunitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events subject to the conditions of Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Box 68760, ₹ resulting in death) Last Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy □ Live birth 2 □ Fetal death □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown After this certificate has been signed in funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 🗆 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 2 12 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other:

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1- Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Montr State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O.

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical Examiner 4c. County of Death 9. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last bigthday) 8. Date of Birth Months Min Yrs Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BaltiMore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Rusiness Industry B. DO NOT use retired) (Give kind of work done during most of working life. DO NOT use retired) Seconday (0-12) College (1-4 or 5+) PK Be 17. Father's Name (First, Middle, Last) 2 19a. Informant's Name/Relations ip (Type, Print) Mailing Address (Street and Number of Method of Disposition 20b. Place of Disposition n (Name of Or oth∉r place) cemetery, cremato Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Interval Between Onset and Death Immediate Cause (Final SEPTIC Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) UROSEPSI Examiner Sequentially list conditions, Examine If any leading to inmedicause. Enter Underlying Cause (Disease or iinjury within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical EUNDGENIC BLADDEN Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant Month Year Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions computating to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Curtifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Curtifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Curtifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Curtifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Curtifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Curtifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Curtifying Nurse Practioner: To the basis of examination and occurred at the time. (Check To the 29b. Signature and title of certifie 29d. Date signed (Month. 2010 DIGITA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FERNANDO 31. Date filed (Month, Day, Year) State SEP 21 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) SCPT Year Physician/ HILL VIRGINIA 0600 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WALKERSVILLE BLVD. FREDERICK DISCOVERY If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number Country) Mb. **Funeral** Min 220-28-3068 98 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 No MO PREDERICK WALKERSVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 8618 21793 DISCOVERY 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black White etc. δ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: BLACK If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Home Elementary/Seconday (0-12) College (1-4 or 5+) HOME MAKER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ MAMIE JOHN Edmund 7 Homas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BARTONSVILLE RO. WILLIAM 20c, Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State FREDERICA Mel Sept 18, 240 ARPONSVICCE COM. Cem 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lipenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or iinjury Examiner Due to (or as a consequence of): signed by the attending physician and debt be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 pronths? Pregnant at time of death 5 Other (specify) 1 | Yes 2/2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 Probably 4 Unknown 1 Tyes completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe ☐ Yes 2☐ No 2 🕽 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 1 Tyes 27. Manner of Deat 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my opinion, death account at the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

2010

SEP

DHMH 17 Rev 7/2009

who completed cause of death (Item 23a) (Type,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ James Medical 4a. Facility Name (if not institution, give street and number) or Location of Death 4c. County of Dear 4b. City. Town. Examiner ٨ Baltimore Union Memorial If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth **Funeral** onth Day Months M 2 🗆 Director Usual Residence of Decedent or 28a-f show 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 ☑ Yes 2 ☐ No laryland 10g. Citizen of What Country? 10e, Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban-Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Armed Black, White, etc Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) Willie Informant's Name/Relationship (Type, Print) Son Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State ramisor 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Dislaz Joint Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No

9 Unknown Month Day Year Pregnant at time of death 4 Pregnant : 9 Unknown Other (specify) signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? death? 1 Yes 2 No certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be 1 Tyes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide iniury 5 Pending 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENTAW ST SNITE 304 BALTIMORE MD 21201 A MHEAH mn 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 17, 2 Pear 10 Physician/ 4:05 AM Edwin C. Hermann, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Greater Baltimore Medical Center <u>Towson</u> 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Min. Davs Hours (Month, Day, Yea 1 🛛 M 2 🗆 F Months Maryland 62 1948 Director 217-50-1355 Usual Residence of Decedent items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Baltimore Cockeysville 10f, Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 21030 USA 25 Warren Manor Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or 1 Never Married 2 XMarried Completed by **Maryland 21215-0036** If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mea College (1-4 or 5+) Elementary/Seconday (0-12) Financial Analyst Citi Financial Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Edwin C. Hermann, Sr. Leona Seymour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan B. Hermann/Wife Cockeysville, MD 21030 25 Warren Monor Ct. altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sept. 20, cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 2010 Timonium, MD Temmon Funeral Home of Dulaney Valley, 10 W, Padonia Road Timonium, MD 21093 Signature of Funeral Service Licensee Michael Flag1e Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner hlud Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be exed Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Pregnant at time of death 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 🗹 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Z No Certificate: To 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

0 j

State

29b. Signature and title of certifier

msaa SEP 21 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29513 For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ 2010 9:45 AM Anne Marie Hurt September 19 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Upper Chesapeake Hospital Harford Bel Air 5. Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 213.58.4136 1 🗆 M 2 🗷 F (Month, Day, Year)
Dec 30 Months Days Hours Min. Director Alaska Dec Usual Residence of Decedent or 28a-f shov 10a, State 10b. County Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Harford Bel Air 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral or items 23a 956 Todd Rd. Apt. G 21015 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married ould be filed within 72 hours after on Mental Hygiene.

marked other than "natural", or Yes 2 No 1 Yes 2 No Specify If Yes, Give 3 Widowed 4 Divorced Specify: Completed Year or Dates White 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 1 Home Maker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Carl Lauermann Juanita Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Leland /Daughter 1404 Allwood Lane. #103 Belcamp, MD 21017 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Sep 2 4 Donation 5 Other (Specify) 2010 Beltsville, Maryland Chesapeake Crematory 21. Signature of Funeral Service Licensee M01443 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Mar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ᇫ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of certificate ha performed death? 2 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1X Yes 2 ☐ No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and place, and due to the cause(s) and manner stated. of this time, date and plane, and dive to the course(s) and manner as stated 29b. Signature and title of certifie MD30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chisapeake 500 Upper

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death sept.19, 2010 Physician/ 5:35pmM Wallace Μ. Hendrick Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a 5510 Sagra Rd Baltimore Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days 1 X M 2 □ F Months Hours Min. 213-34-0097 Director 73 Feb. rginia Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Directo MD 1 XYes 2 No n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5510 Sagra Rd. 21239 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Yes 2 No If Yes, Give 1 954-1957 Year or Dates. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black Completed 3 Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Social Security Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wallace B. Hendrick Addie B. Kidd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eartha L. Herdrick (wife) 5510 Sagra Rd. Balto, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Sept.cem:2010 Garrison Forest Balto, Md. 21. Signalure of Funeral Service License 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTIMORE, MD 21213 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician una cancer Medical resulting in death) Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) signed by the attending physician be detached for use as the buria Physician/Medical requires that the death certificate be Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ pe 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should peen 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? the Hospital or Attending Physician: The law autopsy 24 hours after death.

Funeral Director: After this certificate has 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury (Month, Day, Year) Natural 5 Pending 1 Yes 2 No M Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) To the Hospital c within 24 hours at To the Funeral D completed filled i Medical 29a. Certifier 1 💃 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my khowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Deptember 20, 2010 D 60203 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 401 North Broadway Johns Hopkins Baltimore, Maryland Rosalyn Juergenson

State Registrar 32. Registra/s Sign

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month OG Physician/ Maureen Robinson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Hospited Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) (Month, Day, **Funeral** 1 □ M 2 🕅 F Months Nov. Director 214-22-8627 83 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County Director N/AMaryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 601 Tunbridge Road 21212 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Yes 2 X No If Yes, Give ò 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 4 years Elementary/Seconday (0-12) Fund Raiser State Government Be 18. Mother's Name (First, Middle, Maiden Surname) Bridie Mary Ryan O'Toole Maryland 17. Father's Name (First, Middle, Last) MAUREEN ည Robert Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 5204 Springlake Way Baltimore, Maryland 21212 Patricia M. Isaacs (daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mary's Church Cem. 9-20-10 22 Name and Address of Facility
Mitchell-Wiedefeld Funeral Home,
6500 York Road Baltimore, Maryl 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral 6500 York Road Baltimore 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ Schemic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Extend to remain growth and Cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Yes signed by the a 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown heart 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension After this certificate has performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 Y No 26. Place of Death (Check only one) Be Other: 4 \(\sum_{\text{Nursing Home}}\) 1 Residence 6 \(\sum_{\text{Other}}\) Other (Specify) ျှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cades 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

04:52 AM

9. Birthplace (State or Foreign

10d. Inside City Limits

1 √ Yes 2 □ No

New York

White

Inc.

Month

Dav

1 ☐ Yes 2 ☐ No

09-16-2010

21212 Approximate Interval Between Onset and Death

2010

N/A

State Registrar

29b. Signature and title of certifier

Mahdi

31. Date filed (Month, Day, Year)

Mazianv

YEZVany

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

REJ000

cause of death (Item 23a) (Type, Print) 5601 Wich Raven Blv. Bathmore, MD. 21239

10-06904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

enny Ingle	1	State of Maryland / Department of Health and Mental -For State Certificate of Death		201	0 29516
Physician	1/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Deat	h Dav Year	3. Time of Death 1951 hrs
Medical Examin		Jenny Lynn Ingle 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De	Septembe	4c. County of D	
		1508 Hazel Street Baltimore			ltimore
Funeral Director		5. Social Security Number 2.16 - 86 - 7195 6. Sex 1 Months Days Hours Months Months Days Hours Months	Min. 09/15	1E	9. Birthplace (State or Foreign Country) MD
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	- 1	MD Baltimore Baltimore			1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What	Country?
		1508 Hazel Street 21226 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No		American Indian, Black,
death w	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Pue	erto Rican, etc.)	White, e	
s after ral", o	≥ -	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2X No specify: or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind	of work done	Specify: 16b. Kind of Busin	White ness/Industry
C1 3 🛁	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use	retired)		,
15-0036 filed within 1 Hygiene. ed other that t, the Medic	ᇍ	8 Homemaker	ame (First, Middle, I	Homem	aker
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	Walter Roberts Ka	thleen	Vance	
MD 2121 2 should be fi th and Mental 1 27 is marked umatic event,	2	19a. Informant's Name/Relationship (Type, Print) Edward Stephenson Brother 2660 Dreyfus Rd W			State, Zip Code)
_ Pa = #	L	20a Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date		City or Town, State
More Pages 1 nent of H ant: If i		1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Crematory or other place) Atlantic Crem	9/12/10	Glen	Bernie MD
Baltimore, permit. Pages 1 an Department of He Important: If ite Important: or other training or other	t	21. Signature of Funeral Service Licenses 22. Name and Address of Facility			& Fun Serv
Physician	+	Thomas Allen PA 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause on each line. Mixed drug (Methadone, Cyclober of the control of th	7090 R1	est, shock, or hear	t Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease a. Diphenhydramine) intoxication			Death
Examiner		or condition resulting in death) Due to (or as a consequence of): b.			
	je l	f any, leading to immediate bue to (or as a consequence of).			
ed nsit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
e executed cian and irial - transit	dical	X UNPENDED AMENDED, 27, 28a-f, per ME G908 10/27/1	10 TT		
760, ficate bo g physic the bur	₩ E	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre		23d. Date of d	lelivery Day Year
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	sician/Me	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			
b. Bo the dea	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contrib	ute to the cause of death?
P.C res that signed be deta	Š		1Ye		Probably 4 🗸 Unknown
ords w requires been should	Completed		24a. Was	psy pri	ere autopsy findings available ior to completion of cause of eath?
Reco	S S		1 Yes		Yes 2 No
ician: s certifi rector,	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other N	ursing Home 5	Residence 6	Other: Scene
of V ng Phys ther thi meral di	1.7	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		how injury occurre	ed medications
ion ttendir death.	aţio	1 Natural 5 Pending Investigation Park Accident Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.			r or Rural Route Number, City
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the staff cleath. al Director: After this certificate has been signed by ted in by the funeral director, page 2 should be detach	Certification	3 Suicide 6 Could not be determined (Specify) residence	or Town, Baltin	State)1508_H	azel St
Division To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only	, and due to the cau	ise(s) and manner a	as stated.
To the within To the comple	Medical	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier 29c. License number	red at the time, date		d (Month, Day, Year)
	<	O.C.M.E.		September	9, 2010
10 ourel		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD Assistant Medical Examiner 111 Penn Street, Baltimore	MD 21201		
1 / 4	ate	1 Co. Designation of the Co. Designation of t			
Regist		0 m 0 4 0040 /3 // // // // // // // // // // // // /		OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month PTEMBER Physician/ 7:06A RICHARD B Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 9. Birthplace (State or Foreign Country) New Jersey Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
May 2, 1924 **Funeral** 1 ★ M 2 □ F Director 219-18-3291 86 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5805 Western View Place 21771 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be med wrum remeated. Department of Health and Mental Hydrene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify White 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced WWII Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Mechanical Engineer Government Contracting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles A. Johnson Kathryn E. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffry Johnson Son 5805 Western View Place; Mt. Airy, MD 21771 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery | 9/21/2010 Baltimore, MD Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 s gnature of Funeral Setvice License 23a. Part 1. Enter the disease, or complications that desised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CONJUSTU disease or condition Medical resulting in death) Due to (or as consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 ☐ No To the Hospital or Autonaments within 24 hours after death.

To the Funeral Director. After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 I DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 2 Accident Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of 9-16-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Konald

E

31. Date filed (Month, Day, Year) SEP 2 1 2010

Miller

32. Registrar's Signature

Airy, MD 21771

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Physician/ Medical Sylen ty Name (if not institution, give street and number, or Location of Death 4b. City. To 4c. County of Death Examiner 1e Moria 2100 If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Funeral 6. Sex Days Months Hours Min. 1 🗆 M 2 🗶 7 Director ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State death with the Maryland 10c. City, Town or Location Director 1 🗷 es 2 🗌 No 10e. Street and Number 20 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 21215-0036 72 hours after 1 🗌 Yes 2 💢 🕠 Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Rusiness Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permt. Page 1 and 2 should be filed within 7. Department of Health and Mental Hylgiene. Important: If item 27 is marked other than any injury or other traumativ. conday (0-12) College (1-4 or 5+) 22 Be Maryland : 17. Father's N ne (First, Middle, Last) ther's Name (First, Middle, Maide ပ္ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Velson augh 10. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Nam. of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Sen e Lic Insee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ MYOCARDIAL INFARCTION disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-transit STAGE that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 for use as the IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Month Day Year 5 Other (specify) Pregnant at time of death ed by the a 9 Unknown P.O. The law requires that the Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been signed I funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsv performed? 1 Yes 2 No Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Naturai 5 Pending injury work? Division 2 🗌 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident
Suicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29c. License number 29b. Signature a 10 Fadden MD DOU 69 164 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DA Bast 31318 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 06800 PM SSa SEPTEMBER 16, 2010 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** BALTIMORE CONTER TowsoN SAINT JOSEPH MEDICAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours Month Day, 1 🗆 M 2 🔀 Director Usual Residence of Decedent 10d. Inside City Limits ral", or Items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City. Town or Location filed within 72 hours after death with the Maryland Director Yes 2 No 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No "natural", Completed 3 Widowed 4 Divorced Year or Dates. Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coo) nformant's Name/Relationship (Type, Baltimore, 20c. Location 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place Burial 2 ☐ Cremation 3 ☐ Removal from State any Injury once. ☐ Donation 5 ☐ Other (Specify) Signatury of Funeral Service Licenses 212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ATHEROSCLEROTIC CARDIOVASCULAR DECADES DISTASE Pnysician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director: name 2 shows that that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth 2 Li Fetal deal 4 Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes Inpatient 2 ER/Outpatient 3 DOA ဂ္ 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0051852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 TOWSON, MARYLAND

DHMH 17 Rev 7/2009

State Registrar

A. BRINKER

31. Date filed (Month, Day, Year)

7601 OSLER DRIVE

ase Type or Print in Black Indelible Ink. Ensure Al	I Copies Are Legible 2010 205	21
State of Maryland / Department of Health and Me	ental Hygiene	<u> </u>

KUNK		1-For State Registrar State of Maryland / Department of Health and Mental Hyg	glene Reg	. No.	
Physici lical Exam	an/	1. Decedent's Name (First, Middle, Last) Willie Edward Johnson	Date of Death Month September		3. Time of Death 1910 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Bayview Medical Center Baltimore		4c. County of Death	1
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 220-94-5199 1 M 2 F 30 Yrs. Months Days Hours Min. Usual Residence of Decedent	8. Date of Birth	(MM/DD/YYY) 9. Bir Foreig Co	
ıd how any Ee,	L	10a, State 10b, County 10c, Cify, Town or Location			10d. Inside City Limits 1 Yes 2 No
vith the Maryland s 23s or 28s-f show s e notified at once,	Director	10e. Street and Number 10f. Zip Code 1773 4 F. Chase Street 11713	10g	Citizen of What Cou	ntry?
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23s or 28s-f she ent, the Medical Examiner must be notified at once	Funeral			14. Race - Amer White, etc.	ican Indian, Black,
iours after o				Specify: 16b. Kind of Business/	Industry
5-0036 iled within 72 hours at Hygiene. I other than "natural the Medical Examin	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) Tele Marketer		Adjustab	ur leBeds
21215- vald be filed Mental Hyg marked ott	To Be Co	Willie & Johnson Annet	te Ca	ider Surname) Om OC er, City or Town, State	lore
MD and 2 sho salth and em 27 is	1	Annette Garne 175 Monthalie 20a. Method of Disposition (Name of cemetery,	2.3	11 more 20c. Location - City or	MD 21218
Baltimore permit. Pages 1 a Department of He Important: If it in injury or other t		1 Meurial 2 Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify: 21. Sig. ure of Funer ervice Licensee	3/2010	Balto.1	_ CU
Physician		12 10/553 Jangle Color Id.	two er Ly Oto espiratory arrest	t show or hear	Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wounds (2) to left arm and chest Due to (or as a consequence of):		1 2Wi / 1 12W	Between Onset and Death
	ner	Sequentially list conditions, b			
ansit	Examine	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.			
60, te be executed hysician and e burial - transit	Aedica l	UNPENDED AMENDED			
sords, P.O. Box 68760, as requires that the death certificate be executed has been signed by the attending physician and 2 should be detached for use as the burial - trans	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Other (Specify) 9 Unknown	ey	23d. Date of deliver Month	y Day Year
P.O. Es that the can be detached	by Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	the cause of death?
of Vital Records, P.O. g. Physician: The law requires that ther this certificate has been signed hereal director, page 2 should be detail	Completed		24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
of Vital Recing Physician: The After this certificate Uneral director, page	Be Cor	25. Was case referred to medical 26. Place of Death (Check on	1 ✓ Yes 2 ly one)	No 1 ✓ Ye	es 2 No
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tending death.	ation:	1 Natural 5 Pending Sep 13, 2010 1733 hrs 1 Yes 2 No No	ubject shot		
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	4 W Homicide determined (Specify) Sidewalk	or Town, Stat '00 Kane Stre	te) et, Baltimore, MD	ıral Route Number, City
o the Ho vithin 24] o the Fu ompletely	Medical	23d. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and du one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	ue to the cause(he time, date an	s) and manner as stat ad place, and due to th	ed. e cause(s)
	ž	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed <i>(Mo</i> September 14, 2	
2		30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201		
Si Regis		31. Date filed (Month, Day, Year) SEP 2 1 2010			
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DHMH 17 Rev 1/2001 OCME 2006

			for State Registrar		State o	of Mar	yland	/ Depa	rtment <i>ificate</i>	of H	ealth eath	and N	1ental Hy	giene Reg. No		010	29	521
			Decedent's Name (First, Midd	e, Last,)								2. Date of D	eath		.,	3. Time of	f Death
	Physicia Medic		Annie Louise J	ohns	son								Septem	ber	17,	2010	4:34	рМ
	Examin		4a. Facility Name (if not institutio			nber)			•		Locatio	n of Death		40	c. County	of Death		
	-		8516 Lindendal 5. Social Security Number	e Di		7 Age (h	n <i>yrs. l</i> ast	hirthday)	Laur		If Und	er 24 Hrs.	8. Date of B		Prin	ce Ge	lace (State o	or Foreign
	Funeral Director		577-62-4182		М 2 🔀 F	7. Age (ii	65			Days	Hours		(Month, D Oct.31	ay, Year) 194	4	Coun		or Poreign
	nd thow	5	Usual Residence of Decedent 10a. State 10b. County	0c. City, 7	fown or Loca	ation							1	0d. Inside Ci	ity Limits			
	/laryla 8a-f s tified	Director	MD Princ	e Ge	eorge	I	Laure	1									1 🗌 Yes	2 🔀 No
	the Na or 2		10e. Street and Number						10f. Zip (Code				10g. C	itizen of	What Cour	try?	
	h with ns 23 nust	Funeral	8516 Lindenda						2070					USA				
020	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	쥴	11. Marital Status 1 □ Never Married 2 ☑ Mar 3 □ Widowed 4 □ Divorce	rried	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.			If	as Decede Yes, specif	y Cuban	, Mexic	an, Puerto	ecify Yes or No Rican, etc.)	can, etc.)		14. Race - American Indian, Black, White, etc. African- Specify: American		
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<u> </u>	be fill lental rked o	욛	Rodman Moor	,									e Gaye	, maraon	Carrain	٥,		
a y	hould and M is mai		19a. Informant's Name/Relations	ship (Typ	e, Print)			19b. Mailing	Address (Street ar	nd Num	ber or Rura	al Route Numb	er, City o	r Town, S	State, Zip C	Code)	
<u>`</u>	and 2 s Health tem 27		Andrew Lee Joh	nsor	ı/ Husl	oand					le D	rive,	Laure	1,MD	207	07		
5	Page 1 nent of ant: If i		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other										20c. Location - City or Town, Sta					
0	permit. Departr Imports any injt	i) ş	21. Signature of Funeral Service	License	е	M	01053						naldson Laurel,				e, P.A	
			23a. Fart 1. Enter the disease, of shock, or heart failure. List	r compl only on	ications that e cause on ea	caused th ach line.	e death. [Do not enter	the mode	of dying	, such a	as cardiac o	or respiratory a	arrest,			Approximat Interval Bet Onset and	tween
4	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	-		(or as a co		1 can	cer o	f t!	ie 1	ung				-	Offiser and	Death
	Examiner				Emph			000.										
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5	g Pny erthis ieral d		27. Manner of Death		28a. Date		28	3b. Time of		c. Injury	at		28d. Describe)	
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200	une nospi nin 24 hou the Funer npleted fill	Medical	29a. Certifier 1 A Certifyin (Check 2 Medical only one) 3 Certifyin	Examin	er: On the ba	sis of exan	nination ar	nd/or investig	gation, in m	y opinior	n, death	occurred at	the time, date	and plac	e, and du	ie to the ca	use(s) and ma	anner stated.
	No.		29b. Signature and title of certific		deur	ım	⋄			e o		981				od (Month, I	Day, Year)	
	7 r		30. Name and address of person	who co	1900	d 6	((<	xin	int)	1220	0 A	nnapo	lis Rd	., #:	229,	Glen	20769 dale,	9 MD
	Stat Registra		31. Date filed (Month, Day, Year) SEP 9 1 2010		32. F	Registrar's	Signature	als										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 20522

	•	State Registrar		_		Cer	tificate	of L	Death			Reg. No.	0 1 0	29.	322
Physicia Medic		1. Decedent's Name (First, Middle \mathbf{F} .	J. John	ıson,	Jr.						2. Date of Dea Septemb		20%	3. Time of 1 5:15	Death A M
Examine		4a. Facility Name (if not institution, Suburban Hospi		d nu m ber)			4b. City, To		r Location hesda		4c. County of Death Montgomery				
Funeral Director		5. Social Security Number 457–38–7191	6. Sex 1 🖾 M 2 [e (In yrs. Ia 80	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours		8. Date of Birt Jan. 30	Year) 930	9. Birth Cour 1 6	place (State or ntry) Xas	Foreign
b o e	Ŀ	Usual Residence of Decedent 10a, State 10b, County		_	10c City	, Town or Loc	ration							10d. Inside Cit	/ Limits
Marylan 28a-f st notified	Funeral Director	Maryland Montg	omery		100.01.		Potoma							1 🗆 Yes	
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deat		11. Marital Status	Arm	Decedent E ed Forces?			Vas Deceder f Yes, specify	t of H	lispanic Ori an, Mexical	gin? (Spe n, Puerto I	cify Yes or No- Rican, etc.)		ace - Ameri lack, White,		
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2 hor 2 hor adject	ble	15. Deceder (Specify only highe	nt's E d ucation st grade comp	leted)		(Give I	ient's Usual (kind of work (done d	during mos	t of worki	ng	16b. Kin d of	Business In	dustry	
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hd 2 shou ealth and m 27 is m		19a. Informant's Name/Relationsh May Joyce Johns		2							ad, Pot				54
DESILITION OF INTERPLIATION Z. 1.2.13-00.30 permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at, once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		from State	Mofi	lace of Dispo Tgomer emator	natory or other	er plac	ce) S	eptemi	ber 19, 010	20c. Locatio	•	own, State Iarylan	d
Dalt permit, Depart Import any inji once,		21. Signatur Fun ral S Ice L	icensee		M001	98 RG	Name and Dobert 200 West	Addre Mo	ss of Facili Pumph ontgo	rey l	Funeral Ave., R	Home/F ockvil	Rockvi le, MD	11e, I ₁ 20850-	nc. -2805
		23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications	that caused	the death	n. Do not ente	er the mode o	of dyin	ng, such as	cardiac o	r respiratory arr	est,		Approximate Interval Betw	
Thysician/	, ,	Immediate Cause (Final disease or condition	my one cause			CESTI	15	1.1	FAD	7	FAIL	URE		Onset and D	
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e Hospit n 24 houn le Funera	Medical	29a. Certifier 1 Certifying (Check only one) 3 Certifying	xaminer: On th	e basis of e	xamination	and/or invest	tigation, in my	opinio	on, death o	ccurred at	the time, date a	nd place, and	due to the ca	ause(s) an d mar	nner stated.
		29b. Signature and title of certifier	Su	0,04	1)				e number	124		29d. Date sign	ned (Month,		
10+1		30. Name and address of person v						Rocl	kvill	e, Ma	aryland				
State Registra		31. Date filed (Month, Day, Year)			ar's Signat	UFO A	revel				-				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day SEPTEMBER Ruth Catherine Jones 17 2010 05:00 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TOWSON BALTIMORE SAINT JOSEPH MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Feb. 16. 1924 Days 1 🗆 M 2 🕱 F Months Hours Min. Mary Land Director 86 217-12-3244 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Timonium Maryland Baltimore ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be 23a Funeral 204 Eastspring Road 21093 U.S.A. items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 ₩ Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 l and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Milton Zepp Howard Narcissus Brittingham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau <u>Gwenda Jones Kelley</u> 4119 Ravenhurst Circle Glen Arm, Maryland 21057 Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Memorial Gardens Donation 5 Other (Specify) 9-24-2010 Timonium 21. Sign ture at FO 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. a Towson, Maryland 21204 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ PNEUMONIA disease or condition Medical resulting in death) Examiner CONGESTIVE HEART FAILURE Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): physiciar by Physician/Medical the as nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown be detached 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No ANEMIA 24a Was an has perform certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical Division of Vital funeral director. Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural Assider 5 Pending Accident Investigation the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the withir 2 only one) 29d. Date signed (Month, Day, often mo D0041410 SEPTEMBER 1 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 JOGINDER 7601 OSLER DRIVE TOWSON P. MEHTA m.D.

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

		Registrar 1, Decedent's Name (First, Middle, Las		/ Department of Health and Certificate of Death		g. No.
Physicia Medic Examir	al	George 4a, Facility Name (if not institution, give	Edward	Jolley 4b, City, Town, or Location of Dr	Month 09	Day Year 18 2010 10:30a 4c. County of Death
Funeral		Northwest Nursi	ng Home 7. Age (In vrs. last t	Baltimore birthdey)	Hrs. B. Dale of Birth	9. Rirthplach (State or Fornig Country)
irector) h	217-74-4883 Usual Residence of Decedent 10s. State 10b. County	47 0	own or Location	106 23	6,3 MD
or 28a-1 :	I Director	MD NA	Bal	timore 101. Zip Code	10	M☐ Yes 2 ☐ f
ns 23a	Funeral	2905 Presstman		21216		U.S.A.
iere. 4 thar "natural", critems 23a or 28a-l show <u>the Medical Esaminer must be notified at</u>	畜	11. Morital Status 1 💢 Nover Married 2 🗀 Married 3 🗔 Wildowed 4 🗔 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2√□ No If Yes, Givo Year or Dates.	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 □ Yes 2 ☒ No Specify:	(Specify Yes or No- lerto Rican, etc.)	14 Bace - American Indian, Black, White, etc. Specify: Black
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/ Health item 27 other tr		Richard Goodwi	in-Brother 200. Place	2.805 Presstman St to of Disposition (Name of petery, cremetory or other place)	reet, Ba	
tant l		X☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Licen	King	Memorial Park 9		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical or Location of Death 4a. Facility Name (if not institution, give street and number **Examiner** eur 100 Birthplace (State or Foreign Country) 8. Date of Birth If Unde Age (In yrs. last birthday) **Funeral** Day Warch Months Hours Min. **M** 2 □ F inia Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Nes 2 □ No 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral 800 2121 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, . Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. δ 1 Neyer Married 2 Married Yes Yes, Give 2 NO ☐ Yes 2 No Baltimore, Maryland 21215-0036 Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ္ Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) torce 22. Name and Address 21. Signature A Emeral Service Lie Baltok D 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. rdiac or respiratory arrest Approximate 23a. Part 1 Interval Between Onset and Death Immediate Cause (Final 153 Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ Month Day Year in the past 12 months? Pregnant at time of death 2 🗀 No cate has been signed by the a page 2 should be detached by 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 呑 No 3 🗌 Probably 4 🗎 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No certificate 26. Place of Death (Check only one) within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be (25. Was case referred to medical Other: 2 No 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury Certificate: (Month, Day, Year) injury 1 🔀 Natural 5 Pending Accident Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0105,81 admost 18,2010 D37573 ted cause of death (Item 23a) (Type, Print) 30. Name and address of person who con

State Registrar 835

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Laşt) 2. Date of Death 3. Time of Death Physician/ 6:48 PM Medical 4a, Facility Name (if not institution, give street and number) 4c. County of Death Examiner 21228 Baltimore County 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** th Day, 1 □ M 2 🗰 F Director Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 Yes 2X No MD Baltimore Halethorpe 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 3021 Pennsylvania Avenue 21227 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ※ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James B. Wheeler Katherine V. Seifert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Barnstorf (Pers. Rep.) 5229 6th Street, Baltimore, Maryland 21225 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore National 09/22/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home Signatur of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner NEOTLASM OF UNCERTAN ETIOLOGY MALIGNANT Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an Vithin 24 hours after death.

To the Funeral Director: After this certificate has become a funeral director, page 2 to a substant filled in by the funeral director, page 2 to a substant filled in by the funeral director. prior to completion of cause of death? autopsy Yes 1 ☐ Yes 2 No 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner?

1 \(\sum \) Yes 2 \(\bar{\chi} \) No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) work? 1. ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) M.D

State Registrar 31. Date filed (M

7 HAMMONDS FERRY RD

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 18, 2010 GORDON LLOYD KENNARD SR 5:50P Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore **Examiner** 4b. City, Town, or Location of Death Presbyterian Home of Maryland Towosn If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours 0971771925 Mary I and 213-20-0273 **Director** 85 Usual Residence of Decedent show "natural", or items 23a or 28a-f shoredical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2xxxNo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6402 Sharon Road 21239 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2XX Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: WHITE If Yes. Give 3 Divorced Year or Dates, Korea Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Soup Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Raymond Charles Kennard Sr Leora Vaughn Boykin 19a. Informant's Name/Relationship (Type, Print) Wife 6402 Sharon Road Baltimore, Maryland 21239 Dolores Josephine Kennard 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Dulaney Valley Mem Grdns 09/23/2010 ☐ Donation 5 ☐ Other (Specify) |Timonium Maryland anature of Funeral Se 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| Atral fibrillation 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 No the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director; After this certificampleted filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 K No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ertifier 29d. Date signed (Month, Day, Year) September 20, 2010 037016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Research M. Green, M. (He Le) St. State 4104

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#2&24a.perPhys#7 perFH, G907, 9/21/2010, WS
State of Maryland / Department of Health and Mental Hyglene For State Registrar Certificate of Death Reg. No. 2. Date of Death7-17-2010 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FUTURECARE - NORTHPOINT BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** J36 - 46 - 138
Usual Residence of Decedent 1.2M 2□ F 76 MAR. 13, 1934 Director NC 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location r than "nstural", or Iteme 23a or 28a-f show the Medical Exercine must be notified at 1 XYes 2 No Director MD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 301 S. CLINTON ST. 21224 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH ROOFER ROOFING ith and Mental Hygis 27 is marked other r traumatic svent, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be THEODORE R. KEMP unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Depertment of Heath ar
Important: If item 27 is
sny injury or other trau THOMAS CAMERON/FRIEND 301 S. CLINTON ST., BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/22/2010 HANOVER, MD ARDENT 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Licensee 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. Dist only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Sta /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner physicien and the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetaf death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□No 1 Yes 2 No 1 TYes After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. injury at Work? 1 Natural 2 Accident 5 Pendina death. 1 ☐ Yes 2 ☐ No investigation М within 24 hours after death To the Funeral Director: / completely filled in by the fi 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitel or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title certifier who completed cause of death (Item 23a) (Type, Print) Stemmers Run Rd 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

10-07203 Ariana Kosok Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Ariana Kosok		- For State	tate of	Maryla			tment of			Menta	al Hy	giene	Reg. No	201	0	29529	
Physician Medical Examine	1/	Registrar 1. Decedent's Name (First, Mid Ariana Glazer		k							- 1	2. Date of D Month Septem	eath Day	Yea		3. Time of Death 1436 hrs	
		4a. Facility Name (if not institut Holy Cross Hospital	on, give str	eet and nu	ımber)	••	(Town, or Le er Spring		Death		4	c. County of Montgon			
Funeral Director		5. Social Security Number 214-41-9494	6. Sex	2 X F	7. Age (In	yrs. las 18	t birthday) Yrs	Mont	der 1 Year hs Days	If Under Hours	24Hrs. Min.	8. Date of Aug.			Foreign	nplace (State or n untry)Guatemala	
ne Maryland or 28a-f show any fied at once.		Usual Residence of Decedent 10a. State 10b. County MD Mont		own or Locati					10d. Inside City Limit								
the Maryl 3a or 28a-l otified at o	<u> </u>	10e. Street and Number 9225 Wendell S	treet					10f. Zip Code 10g. Citizen of What Country USA						try?			
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3036 within 72 hours iene. er than "natu Medical Exam	Elementary/Secondary (0-12)							dent's Usual Occupation (Give kind of work done g most of working life. DO NOT use retired) dent 18.Mother's Name (First, Middle,						16b. Kind of Business/Industry High School			
MD 21215-0036 d 2 should be filed within 7 d 1 should be filed within 7 h 17 is marked other than sumatic event, the Medica	8	17. Father's Name (First, Middl Karl Fredrick 19a. Informant's Name/Relation	Koso				19b. Mailing	Addres	s (Street	Emily	Ru er or Ru	th G1a	azer	City or Tow	n. State.	Zip Code)	
e, MD 2 l and 2 shou Health and l item 27 is r traumatic	Ĺ	Emily Glazer,	mothe	r			9225 ace of Disposematory or other	Wen	dell	St. S	Silv	er Sp:	ring	, MD	2090	Town, State	
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite Important: If ite Imjury or other tr	,	4 Donation 5 Other Specify:							emato d Address	of Facility	Rap		eral		emat	ion Svcs.	
Physician	1	23a. Part I. Enter the disease, of failure. List only one caus	or complicate on each I	ions that c	aused the	death. D	9 00 not enter the	33 G	ist A	ve. S	Silv rdiac or	er Sp	ring arrest, sl	hock, or hea	209] irt	Approximate Interval Between Onset and	
Mudical Examiner	Ì	Immediate Cause (Final diseas or condition resulting in death)	Due	monary to (or as a												Death	
pa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of):																
execu an and al - tra	UNPENDED AMENDED																
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buritable of the control of th	SICIAN/I	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 ✓ U	the 1		oirth nant at time		2 Fe	tal death ner <i>(Sp</i> e	_	Ectopic	pregnan	псу		3d. Date of Month		ray Year	
ires that the de signed by the	a	Part II. Other significant cond	itions cor	ntributing to	o death bu	it not res	ulting in the u	nderlyin	ig cause giv	ven in Parl	i.l.			o use contri	_	the cause of death? ably 4 Unknown	
Division of Vital Records, P.O. all or Attending Physician: The law requires that the law free death. The	Completed	completed										_	1 ✓ Ye	topsy rformed?	? p	Vere autrior to ceath?	topsy findings available ompletion of cause of
F Vital Rec Physician: The I r this certificate I	8	25. Was case referred to medic examiner? 1 ✓ Yes 2 No		ital: 1	Inpatient	2 🗸 E	R/Outpatient	3		Other 4	Nursing	nly one) Home 5	Resid	dence 6	Other	:	
ion of tending Pleath. tor: After the funera			nding estigation	28a. Date (Month	of Injury n, Day,Year)	2	28b. Time of I	njury	28c. Injury	at Work?	No	28d. Describ					
Division of North Hospital or Attending Ph. within 24 hours after death. To the Funeral Director. After it completely filled in by the funeral completely filled in by the funeral conditions.	Certification:	3 Suicide 6 Co	uld not be ermined	(Specify)			ne, farm, stree					or Towr	, State)			ral Route Number, City	
To the Ho within 24 To the Rt Co the Rt completel	adica	(Check only one) 2 Medical Ex	aminer: On and	the basis manner s	of examina	ation and	e, death occur d/or investigat	ion, in m	ny opinion,	death occ	urred at	the time, da	ite and p	olace, and d	ue to the	e cause(s)	
		29b. Signature and title of certif						29	O.C.M					n. Date signe eptember	•	oth, Day, Year)	
31		30. Name and address of personanti, M. Vincenti, M.		pleted cau sistant N				Penn	Street, l	Baltimo	re, MC	21201					
Stat		31. SEP 2 1 2010	h	32. R	egistrars S	Signature	while		-	_				• •			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month SEPT Day (F Year 2010 KING Physician/ 5.30 AMCAMILLA Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner George's Palinxent River Health of Rehale Louvel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6 Sev 7. Age (In vrs. last birthday) Country) AL **Funeral** Months Days Hours Min 02/18/1948 1 🗆 M 2 🗶 F 421-68-5648 62 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location Director P.G. MD 1 🗌 Yes 2X No Beltsville 10g. Citizen of What Country? 10f, Zip Code 10e, Street and Number 20705 Funeral 4511 Romlon St. Apt 3 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Who If Yes, Give 14. Race - American Indian. 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Gov't Contractor Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Ross Wesley Brown Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Son 2504 Vivaldi Ave Gambrills MD 21054 Victor L. Brown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1 Burial 2X Cremation 3 Removal from State 09/18/10 Glen Bernie MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crem 22. Name and Address of Facility Simplicity Crem And Fun Ser Thomas Allen PA 7090 Ridge Rd Hanover MD 21. Signature of Euneral Service License ex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final months Physician/ Lung Metastatic Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Year Month Day 4 Pregnant a Pregnant at time of death led by the a detached f cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🔀 Yes 2 🗆 No 3 🗆 Probably 4 🗀 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 M Nursing Home 5 - Residence 6 - Other (Specify) Certificate: To 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 28b. Time of funeral 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident the 1 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check To the h within 2. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number alyan2 D 53411 2010 J. Shesadni 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20715 Bowie MD 14300 Gallow Fox 210

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year

SEP 21 2010

32. Registrar's Sgnature

Registrar

State

				Please	e Type or Pri					_		gible.				
			For State Registrar		State of M	aryland		artment of I tificate of I		Mental Hy	giene Reg. No. ()	10	29532			
	Physicia Medic		1. Decedent's Name (Fin Arthur	st, Middle, La	ast)			Lewis		2. Date of De			3. Time of Death 5:14 P M			
*	Examir		4a. Facility Name (if not i		e street and number)	-			or Location of Dea		4c. Cour	nty of Death				
	Funeral Director		5. Social Security Number 223–14–64	er 6. 5		e (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days		s. 8. Date of Bir	y, Year)	9. Birthpl Counti	ace (State or Foreign ry) VA			
	aryland a-f show fied at	ector		o. County			Town or Loo					10	od. Inside City Limits 1 X Yes 2 □ No			
	the Ma a or 28a oe notif	Funeral Director	MD 10e. Street and Number			_ B	31 (1)	10f. Zip Code			10g. Citizen o	of What Count				
	th with ms 23s	inera	3113 Thom	cnfiel			1.0.1		207	0 " -) ()		S.A.				
Maryland 21215-0036	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status1 ☐ Never Married3 ☐ Widowed 4 ✗		12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		li li	Was Decedent of F f Yes, specify Cub-	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	В	14. Race - American Indian, Black, White, etc. Specify: Black				
15-0	72 hour	nplet	(Specify of		Education rade completed)		(Give I	lent's Usual Occup kind of work done	during most of w	orking	16b. Kind of	Business Ind	ustry			
212	led within Hygiene. other than ent, the N	S	Elementary/Seconda 8th grade	ıy (0-12)	College (1-4 or na	5+)		ONOT use retired, Letter		<u> </u>	U.S.P	ostal	Service			
and	e filed ntal Hy ed oth event	To Be	17. Father's Name (First,)				l .	ame (First, Middle, e Burke	Maiden Surna	me)				
aryla	2 should be file th and Mental I ? 7 is marked o traumatic eve	ľ	John Lew: 19a. Informant's Name/		Type, Print)		19b. Mailir	ng Address (Street		Rural Route Number	er, City or Town	, State, Zip C	ode)			
			Yvonne P		-Daughter		311	3 Thorn			altimo	re, M	1d 21207			
nore	= 0			remation 3	Removal from State	cen	netery, cren	sition (Name of natory or other pla		Date		n - City or To	wn, State Mills, M			
Baltimore,	permit. Page 1 Department of Important: If i any injury or once.		4 Donation 5 D			Gar	22 M	Name and Addre	ess of Facility H West	9/17/20 e, Balt			21215			
			23a. Part 1. Enter the d shock, or heart fail	isease, or cor lure. List only	nplications that dause one cause on each lin	d the death. e.							Approximate Interval Between			
	Pnysician/ Medical	1	disease or condition resulting in death)		a Due to (or as	sep:	315					-	Onset and Death			
	Examiner	L	Sequentially list condition	one	b Due to (or as	ORC		Ry Qu	rteru	dise	ase					
	ed isit	Examine	Sequentially list conditi- it any, leading to immo- cause. Enter Underlying Cause (Disease or iinjur	diate	Due to (or as	a conseque	nee of,:	,				-				
	oe executed ician and burial-transi		that initiated events resulting in death) Last		c. Due to (or as	a conseque	nce of):									
09,	ate be ohysicia the bur	edical			d											
Box 68760	hat the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 Yes 2 No 9 Unknown	ths?	23c. If yes, outcome 1 Live Birth 4 Pregnant: 9 Unknown	2 Fetal of	death 3	Ectopic pregnan Other (specify)	ісу			Date of delive Month	ery Day Year			
ls, P.O.	uires that th signed by lid be detac	ed by Ph	Part II. Other significan		contributing to death I								e cause of death?			
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Completed by	Myoccirclia Replacent			erten			al knec	24a. Was auto perf 1 \(\sum \) Yes		b. Were autop prior to cor death? 1 \(\sum \) Yes	osy findings available inpletion of cause of 2 No			
ital	ician: certifica rector, I	Be	25. Was case referred to examiner?	medical	Hospital:			26. F	Place of Death (Cl							
on of V	To the Hospital or Attending Physician: within 24 hours after dear after dear To the Funeral Director After this certific completed filled in by the funeral director,	cate: To	27. Manuer of Death 1 Natural 2 Accident	Pending	28a. Date of inju	ury 2	R/Outpatier 8b. Time of injury	28c. Inju	ry at	28d. Describe	dence 6 C					
Divisio	al or Atte s after des il Director ed in by th	Certificate:		Could not determined	be 28e. Place of In	jury - At hom c. (Specify)	e, farm, str	eet, factory, office		28f. Location (City or To		nber or Rural	Route Number,			
	he Hospit iin 24 hour he Funera ipleted fille	Medical	(Check 2 ∐ I	Medical Exar	ysician: To the best o miner: On the basis of urse Practioner: To the	examination a	and/or invest	tigation, in my opin	ion, death occurre	ed at the time, date	and place, and	due to the cau	use(s) and manner stated			
	with Son Con		29b. Signature and title	of certifier	Mari	5	11	29c. Licens		_	29d. Date sig					
U			30. Name and address of	of person who	completed cause of	death (Item 2	3a) (Type, F	Print)	57085	d	Septer	nuer	5,8010			
1			Redetta	Morr	¿ an ci	Sinai	Hosp	ital of	2 Balt	mure.						
	Sta Registr		31. Date filed (Month, Da SEP 2			ar's Signatul	far	41								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | 0 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month EPTEMI Stewart C. Lafferty, III 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 1017 Misty Lynn Circle Apt. G Cockeysville 9. Birthplace (State or Foreign MD country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours April 23, Year 951 59 212-58-6357 **Director** Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State should be filed within 72 hours after death with the Maryland Director 1 Yes XX No MD Cockeysville Baltimore 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Jancons 2011 and happiene.
I so marked other than "natural", or items 23a or
I is marked other than "natural", or items 23a or Completed by Funeral U.S.A. 21030 1017 Misty Lynn Circle Apt. G 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 - Married 1 ☐ Yes 2XX No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes YV No Specify: Specify: White 3 - Widowed 4 - Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours popartment of health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Court Commisioner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Vivian Williams Stewart C. Lafferty, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian Lafferty (Mother) 4404 Falls Bridge Dr. Apt. K Balto, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 9/22/2010 Glen Burnie, MD 22. Name and Address of Facility Burgee Henss-Seitz Funeral Home, 3631 Falls Road Balto, MD 2121 . Signature of uneral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INTARCTION MYOCAR Physician -DIAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner SALVID Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by is certificate has been sfgne director, page 2 should be 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ပ 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA 4 I Nursing Home this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death

1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 \square Pending 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number 16,2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE JOSSA State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Logan M. Lowers Sr. 19,2010 11:15 September 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Franklin Square Baltimore Rosedale Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number Months Days Hours 1**№** M 2□ F 170-12-2069 June9,1919 PA Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes X No Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21221 930 Barron Avenue 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces TYes 2 No fYes, Give 1 Never Married 21 Married White 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Steel Worker Beth Steel 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Laura Miller Roy M. Lowers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 930 Barron Avenue Baltimore MD 21221 Hannah E. LOwers /wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 9/23/10 Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of usual Syvice Lo 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MOSE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 □Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner The law requires that the death certificate be executed

Examiner

Physician/Medical

Completed by

Be

၉

Certification:

Medical

29a. Certifier

Physician

/Medical

Examiner

10a. State

Director

Funeral

Be Completed by

2

MD

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Im Midical Expression 2000.

ng physician and as the burial-tran attending p i signed by the a d be detached for has been certificate Hospital or Attending Physician:

O. Box 68760.

σ.

of Vital Records,

Division

the

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

25. Was case referred to medical examiner? 1 Yes 2 No 27. Man r of Death 1 Natural

5 ☐ Pending investigation 2 Accident 6 Could not be 3 ☐ Suicide determined 4 Homicide

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D0069314 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mittal Prayapath, 8813 Waltham Woods Rd, Parlimble MD

32. Registrar's Signature

State Registrar

(Ov

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 September 8:57 A M Mary A. Loverde Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign Country)
Maryland 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Hours Dec. 30 1 □ M 2 💢 F 1927 Director Yrs 215-24-5884 82 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 🗆 Yes 2 🙀 No MD Baltimore Baltimore ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 8800 Walther Blvd. 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 ♥ Widowed 4 □ Divorced white Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 8 Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Gaitley Marie Brandt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman J. Loverde 543 Valley View Road; Towson, MD 21286 son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 CAmation 3 Removal from State 4 Donation 5 Dother (Specify) Dulaney Valley Mem Gardens 9/20/2010 Timonium, MD 21. Signature of Funeral 22. Name and Address of Facility 1050 York Road MD 21204 Ruck Towson Funeral Home, Inc. Towson, 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease of impury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Records, P.O. Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. within 24 hours after death.

To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?
1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 6 Other Specify HUSACE မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death

1 X Natural
2 Accident Certificate: Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) 10 ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and SEP 21 20 State 2010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1, per MD C907 9/24/10 TT

Amend Item 23a per mp, g907, 09/30/2010dnb

Corticoto Copies Are Legible. For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Gilbert Richard Long 3. Time of Death Physician/ Month 1:55 P M 2010 Gilbert Robert September Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Carroll Manchester North Pines If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign Funeral 6. Sex 7. Age (In vrs. last birthday) Days Nov. 16 Year 1925 1 X M 2 T F Hours 84 Marviand Yrs Director 220-18-4076 Usual Residence of Decedent 28a-f shov 10a State 10h. Count 10c. City, Town or Location notified at 10d. Inside City Limits Director Manchester Carroll 1 Yes 2 X No Md. 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a USA 21102 3316 Wilhelm Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. traumatic event, the M. diral Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc ö 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: "natural", Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Interior Decor. 0wner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mabel Taylor Robert Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 2331 Convey Dr. Manchester, Md. 21102 Mrs. Diane Dabney/ Niece injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Pikesville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 9-21-10 21. Signature of Fun ral Satvice License Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. any 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Debility 1 yr. Sequentially list conditions, Examiner que to (or as a consequence of) cause. Enter Underlying Hyperlipidemia Unknown Cause (Disease or linjury burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical Unknown Hypothyroid Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for 5 Other (specify) Month Year Pregnant at time of death Day ☐ Pregnant ☐ Unknown Yes the 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be c 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe certificate has Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 🛣 No Certificate: 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director; Af completed filled in by the fu NIA Accident Suicide 24 hours after death Funeral Director; A Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

**Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10x1 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mo Registrar's Signature State SEP 21 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician/ P. Howard Mayr 1250 D M 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Agnes hospital Baltimore N/A Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 👿 M 2 □ F Months Days April I, Year 1946 64 Maryland Director 217-46-3096 Usual Residence of Deceden "natural", or items 23a or 28a-f show edical Examiner must be notified at and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MD **Baltimore** 1 Yes 2 X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5611 Edmondson Avenue 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 😿 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: 3 Widowed 4 Divorced Completed White Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Wholesale Hardware Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Henry Mayr Margaret Janning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5611 Edmondson Avenue Baltimore, MD Melvia A. Hagan wife 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot
once. Metro Crematory, Inc. 09/21/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. Sery 299 Frederick Road Baltimore, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Preumonia mart Medical Due to (or as a consequence of) Examiner ears aestive 00 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): sician and burial-transit Cause (Disease or iinjury The law requires that the death certificate be executed ui دع that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician the for use as the buria Physician/Medical IF FEMALE: use yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death Month Year 1 Yes 2 L 9 Unknown 2 No detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Records, 1 Pes 2 No 3 Probably 4 Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed' 1 Yes 2 No or Attending Physician: Division of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1110 Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred May injury 1 Natural 5 Pending death. 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 📙 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD Dalasi Vandana 234 20 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Battimore MD - 2122-9 caton Avenue Dalagiri 900 Vandana 31. Date filed (Month, Day, Year) State SEP 21 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 09 - 17 - 2010 Physician/ 730 P Marie Grace Martin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) Birthpiaco (Country) MD **Funeral** Days 1 M 2 X F 07-21-1928 82 Director 220-20-5180 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland De artment of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show am injury or other traumatta event, the Medical Examiner must be notified at one. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rosedale Baltimore 1 Yes 2 X No MD 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral USA 21093 939 Rosedale Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Specify: White If Yes, Give 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည DiMartino Beatrice Cusimano Andrew 19a. Informant's Name/Relationship (Type, Print) (Daughter) Carol Bethke 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State Gardens of Faith Cem. 09-21-2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses of Facility
Schimunek Funeral Home of BelAir
MacPhail Rd Bel Air MD 21014 Inc 610 W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one quuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lun disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending abuse and the attending physician and hed for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical) Aに MACTIN Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 ponths?

1 Yes 2 No
9 Unknown Month Day Year cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfor 2 🗆 No 1 🗌 Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, examiner? Hospital: မ 1 Tyes No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Dea Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and til 2010 person who completed cause of death (Item 23a) (Type, Print) Vimonium

DHMH 17 Rev 7/2009

State Registrar

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			For State Registrar	State o	of Marylan		rtment of			-	giene Reg. No. (110	2953	9
	Physici		1. Decedent's Name (First, Middle, L.	•						2. Date of De 09-16-	ath	Year	3. Time of D	eath
	/Medic	al	Willa B. Medinger		rmb or)	- -	4b. City, Town	or Location	of Death	09-16-		ounty of Death	545 A	М
	Examin	er	4a. Facility Name (If not institution, gi 2806 Wesleyan Da		(Tiber)			hurchy			10.0	Harfo		
Ī	Funeral Director	0.45		Sex 1 □ M 2 🛣 F	7. Age (In yrs. 73	last birthday) Yrs.	If Under 1 Ye Months Day		r 24 Hrs. Min.	8. Date of Bir 0 1 – 20 –	1937	9. Birth Cos	nplace (State or untry) MD	Foreign
	pu »	ä	Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation						10d. Inside City	Limits
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	r 28a-	Director	10e. Street and Number				10f. Zip Code	е			10g. Citize	en of What Co	untry?	
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מ	be filed within 72 hours after death with the Marylan ttal Hygiene. od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Las	st)				18. Mot	her's Name	e (First, Middle	, Maiden S	urname)		
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Maryland 21215-0036	2 sh and is m		19a. Informant's Name/Relationship STephen Medinger				ng Address <i>(Stro</i> Wesley						Zip Code)	
	s 1 and of Health item 27 other to	- 2	20a. Method of Disposition	(5011)	20b. F		sition (Name of matory or other			Date		ation - City or	Town, State	
ō E	Pages Tent of I Int: If its		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		i State		Mem. G		09-20	0-2010	Fall	ston,	MD	
Baltimore,	permit. Pages Department of I Important: If Ite any Injury or o	. 1	21. Signature of Funeral Service Lic	ensee PM L	2.1	1	2. Name and Ad		200	himunek Rd Bel	Fune	ral Ho MD 210	me of Bo	elAir
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Box	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		utcome pf pregn birth 2 ☐ Feta		∃Ectopic pregna	ancy			25	3d. Date of de Month	•	ear
0	at the dea by the a stached fo	ysic	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4□Preç 9□Unk	gnant at time of one of the contract of the co	death 5	Other (specify	")					,	
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a E			BSCOD							1□ Yes	formed? 2 No	death? 1 ☐ Yes	2 □ No	
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Division or	ng Phys fter this neral dir		27. Manner of Death 1 X Vatural 5 Pending	28a. Date	e of Injury enth, Day Year)	28b. Time o		injury at Work?		28d. Describe				
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_	Hospita 4 hours Funeral	edical C		aminer: On the	ne best of my kn basis of examin inner stated.)
	To the Hos within 24 hd To the Fur completely	Me	29b. Signature and title of certifier				29c. Lic	ense numbe	er			e signed (Mon	th, Day, Year)	
			hund Kley	Cen-				31295			9/1	210		
			30. Name and address of person wh		use of death (Ite	m 23a) (Type,	Print) I Ave	3.	ار مد ملا	e ma	212	206		
	₹ Sta	ate	31. Date filed (Month, Day, Year)		Registrar's Sign	ature	,	P	., , , , , , , ,					
	Regist	rar	SEP 2 1 2010	Cenera	D. 4	and								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mando Physician/ Mohamed Month Year 09 2010 9 - 30n Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 9402 Goodspring Drive Baltimore Perry Hall 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05 29 Birthplace (State or Foreign Country) **Funeral** 1**X**□ M 2 □ F Months Days Hours Min Director 052-78-9443 Egypt Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 X No Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9402 Goodspring U.S.A. Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black. White, etc. þ 1 Never Married 2 Married ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade King Tut Jewelry Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ lya Mandur Ahmed Mandur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Ann Ct, Owings Mills, Md 21117 <u> Ashraf Bakr-Brother</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 9/20/2010 Woodlawn, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21. Signature of Funeral Service Lice ala 21215 Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year been signed by the should be detached 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has yes 2 After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 🗹 No Other: ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at ☑ Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Director 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined . 24 hours a e Funeral I Medical 29a. Certifier Certifying Physic [an, To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continuing Nurse Planting or T. to be set in a continuing Nurse Planting or T. to be set in a continuing Nurse Planting or T. to be set in a continuing Nurse Planting or T. to be set in a continuing Nurse Planting or T. to be set in a continuing Nurse Planting or T. to be set in a continuing Nurse Planting or T. to be set in a continuing Nurse Planting or T. to be set in a continuing Nurse Planting or T. to be set in a continuing Nurse Planting or T. to be set in a continuing Nurse Planting or T. to be set in a continuing Nurse Planting or T. to be set in a continuing Nurse Planting Nurse Planting Or T. to be set in a continuing Nurse Planting Nurse Plan (Check within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person w

21

31. Date filed (Month, Day, Year)

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completed cause of death (Item 23a) (Type, Print)

32. Fegistrar's Signature

Please Type or Printin Black Indelible Ink. Ensure All Copies Are Legible.

Cecelia Beatrice I		CNEII 1- For State Registrar	St	ate of Maryla		artment ο rtificate ο		and iv	vientai H	F	Reg. No.	2010	29541
Physiciai Medical Examin	er	1. Decedent's Nam		,	В		Mitch			2. Date of De Month Septemb	Day er 17, 20		3. Time of Death 2030 hrs
		4a. Facility Name (i University F		n, give street and nu	mber)		4b. City, Town Baltimore		ation of Death	1	4c. C	ounty of Dea	ith
Funeral Director		5. Social Security N 216-42-4	4239	6. Sex	7. Age (In yrs. I	-		$\overline{}$	Under 24Hrs Hours Min	1		Fore	Sirthplace (State or eign country) MD
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Ŝ	12th gra	(First, Middle,	·	S	Benii	Earn	18.N	other's Name	(First, Middle,	Maiden Su		Security
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Baltimore, permit. Pages I an Department of He. Important: If ite		4 Donation 5 21. Signature of Fu			Ki		norial Name and Addr arch F			23/20	10 W		wn, Md
Physician	1	23a. Part I. Enter the	e disease, or ly one cause	complications that ca	aused the death	43	300 Wa	bas	sh Ave	r respiratory ar	timol rest, shock	ce, M or heart	d 21215 Approximate Interval Between Onset and
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Box 6876 death certificate he attending phy d for use as the l	Sician/	3b. Was decedent past 12 months	?	e 1 Live b	irth ant at time of de	2 Fe	etal death ther (Specify)	3E	ctopic pregna	incy		onth	Day Year
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Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - transi	Completed									24a. Was auto perfo	psy ormed?		
Vital Recysician: The his certificate director, page	<u>۾</u>	25. Was case referrexaminer? 1 ✓ Yes	red to medical	Hospital: 1	npatient 2	ER/Outpatient			eath (Check of	only one) g Home 5	Residence	e 6 Oth	er.
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director. After this certificate I completely filled in by the funeral director, page	ation: 10	27. Manner of Deat	h 5 Pend	28a. Date	of Injury	28b. Time of I 1940 hrs	· · _	njury at		28d. Describe Subject ass	how injury		
Division To the Hospital or Attent within 24 hours after death within 24 hours after death completely filled in by the	Certification:	3 Suicide 4 ✔ Homicide	6 Could	not be 28e. Place	of Injury - At ho Townhouse		•	e buildii		28f. Location or Town, 1533 North S	State)		tural Route Number, City ore, Md
Divi: To the Hospital or 4 within 24 hours after completely filled in the completely filled in t	<u>ا چ</u>	29a. Certifier 1 (Check only one) 2		nysician: To the bes miner: On the basis of and manner si	of examination a	-							
E * E 8	Me	29b. Signature and	title of certifie				29c. Lice O.	ense nui C.M.E				e signed <i>(M</i> mber 18,	onth, Day, Year) 2010
)	-	30. Name and addre		who completed caus Assistant M	e of death (Item	i i	Penn Stre	et, Ba	ltimore, M	D 21201	1		19.00
Sta Registr	te	31. Date filed (Mont			gistrar's Signatu	_							

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Vear Month /Medical 20/0 4a. Facility Name (If not institution give street and number 4b. City Town, or Location of Death 4c. County of Death Examiner C-1/12 9-1CWG M If Under 1 Year | If Under 24 Hrs. rity Number 7. Age (In yrs. last birthday) **Funeral** Months Days Director Usual Residence of Decedent 1∩a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it a M-silcal Examinat must be retified at BaltiMore 1 Yes 2 □ No Director 10e. Street and Number. 10g. Citizen of What Country? 19W000 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race -American Indian, Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or item any Injury or other traumatic event, Item Martine English once. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working DO, NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ruc 17. Father's Name (First, Middle, Be ဥ Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 21. Signature of Funer Service Licensee Name and Address of Facility Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MITEL 15 GASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Division of Vital Records, P.O. Box 68769 Due to (or as a consequence of) :tor: After this certificate has been signed by the attending physician the funeral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ MMONE 2 No Be Completed 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only on examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 2 Accident 1 □Yes 2 □No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 1 10 DANIEL DINO MCGEE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HIGNIG If Under 1 Year If Under 24 Hvs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) (Month, Day, Year) 1**X** M 2 □ F Months Days UNKN 53 Yrs Director MD Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No BALTIMORE MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 225 S. EATON ST <u> 21224</u> USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes Yes, Giv 2 X No Specify: WHITE 1 ☐ Yes 2 X No Specify. 3X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ROOFING 12TH ROOFER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ LORRAINE DAWSON GEORGE A. McGEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL R. MCGEE/BROTHER BALTIMORE, MD 225 S. EATON ST., 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ☐ Burial 2 🛣 Cremation 3 ☐ Removal from 4 Donation 5 Other (Specify) 09/15/2010 ARDENT HANOVER, MD 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. Signature Funeral Servi 2007-09 EASTERN AVE., BALTIMORE, r complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each me. 23a, P. 1. Enter the disease Approximate Interval Between Onset and Death shock, or heart failure Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): ending physician are use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29d. Date signed (Month, Day, Year) 2050

State Registrar 31. Date filed (Month, Day,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

550

or Print in Black Indelible Ink. Ensure All Copies Are Legible.

o7109 in L. Mathew	ıs, S	r. State of	Maryland / De	epartme	ent of H	Health a	and M	/lenta	l Hygi	ene	201	0 29544
		1- For State Registrar		Certifica	te of L	Death			121	Reg	. No.	3. Time of Death
Physici		1. Decedent's Name (First, Middle, Last) John L. Mathews, S:	r.						s			2051 hrs
		4a. Facility Name (if not institution, give stre	eet and number)			City, Town, Baltimore		ation of D	Death		4c. County of Dea	
		Union Memorial Hospital 5. Social Security Number 6. Sex	7 Age/In	yrs. last birth		If Under 1		f Under 2	24Hrs. 8	. Date of Birth	(MM/DD/YYYY) 9. E	Birthplace (State or
Funeral Director		5. Social Security Number 6. Sex 212-34-6329			Yrs.			Hours	Min.	Jan 29,	1Fore	oign Country)Maryland
		Usual Residence of Decedent										10d. Inside City Limits
w any		10a. State 10b. County N/A	10c.	City, Town o		1						1 Yes 2 No
ryland a-f she	Director	10e. Street and Number		Dell'		10f. Zip Cod	le			100	g. Citizen of What Co	ountry?
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h with ems 23 t be no	Funeral	11. Marital Status 1 Never Married 2 Married	. Was Decedent Ever Armed Forces?		13. Was I If Yes	Decedent of s, specify Cu	f Hispan uban, Me	nic Origin exican, P	? (Specii uerto Ric	fy Yes or No- an, etc.)	14. Race - Am White, etc.	erican Indian, Black,
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. ten 27 is anaked other than "natural", or items 23a or 28a-f sho fraumatic event, the Medical Examiner must be notified at once	Fur			No	1 Y	es 2XX	No s	pecify:			Specify: Wh	ite
ours af atural	À P	Or.	Dates: ighest grade complet	ed) 16a. [Decedent's	Usual Occu	upation life. DC	(Give kin	nd of work se retired)	(done	16b. Kind of Busines	s/Industry
36 in 72 h han "n Iical E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		Maint	enance					Catholic A	Archdiocese
21215-0036 suld be filed within 7 IMental Hygiene. I marked other than ic event, the Medica	l oo	17. Father's Name (First, Middle, Last)					18.1				aiden Surname)	
1215 be file antal H irked	Be	Stanley Mathews, Sr.		Lion	Mailing	Addross (6	Treat or	Pea	ari Ro	osebud L	awson per, City or Town, St	ate, Zip Code)
MD 21 nd 2 should alth and Me m 27 is ms aumatic eaumatic	٦			190	o, Maining	212 210 Mt	. Car	rmel I	Road,	Upperco	, MD 21155	
e, M l and 2 Health item 2		20a. Method of Disposition	D I for Otalo	20b. Place o	of Dispositi		f cemet	ery,	D	ate	20c. Location - City	or Town, State
MOF Pages lent of unt: If		1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State	Mays C	hape1	Cemete				1/2010	Timonium, N	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other fraumatic event, the Medical Examiner.		21. Signatu e Juneral Service Licensee	Dens	1)	22 Na Bur	me and Add	ress of	Facility Seitz	Funer	ral Home	, Inc. 212 vland	11
Physician	_	23a. Part I. Enter the disease, or complica	tions that caused the	death. Do no	ot enter the	mode of dy	ying, suc	ch as car	diac or re	espiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medica	1		lypertensi		eros	clerot	tic	card	liova	scular	disease	Death
Lxamme		h	e to (or as a conseque	ence of):								
	miner	Sequentially list conditions, if any, leading to immediate Due to cause. Enter Underlying Cause	e to (or as a conseque	ence of):								
λ. :	1 9	(Disease or injury that initiated events resulting in death) Last	e to (or as a conseque	ence of):								
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	Dhysician/Modical	IF FEMALE:	#19b.t 23c. If yes, outcome of	oerFH.Cof pregnancy	907,9/	/28/10 _• W	VS				23d. Date of deli	
ox 68760, anth certificate be attending physici	in se as	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at tim	. F .d Ma		al death er (Specify)		Ectopic	pregnanc	У	Month	Day Year
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IS, P.C quires that en signed			rive burmo	nary c	irsea	se; M	LLIA	<u> </u>		24a. Was		e autopsy findings available to completion of cause of
Division of Vital Records, P.O. ral or Attending Physician: The law requires that t as after death.	, page 2 should be	Valve prolapse								autop perfor	rm <u>ed</u> ? deat	h?
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Spital o	filled	determined Homicide	(Specify)							his to the calls	ca(e) and manner as	stated
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician to the Funeral Directors.	201	Check only 1 Certifying Physician one) 2 Medical Examiner: 0	n the basis of examin	nowledge, de nation and/or	eath occuri investigati	red at the tin ion, in my op	ne, date pinion, c	death occ	ce, and d curred at	the time, date	and place, and due	to the cause(s)
To T	con	29b. Signature and title of certifier	nd manner stated.)		1 -	icense				29d. Date signed	
		Patrace Gro	nica t	olla	k.s		D.C.M	I.E. ———			September 1	
(d)		30. Name and address of person who con Patricia Aronica-Pollak MD.	mpleted cause of dea Assistant Me			111 Pen	n Stre	eet, Ba	ltimore	, MD 2120	1	
I	Sta	at D. C. El Wildowth Day Voss	32. Registrar's		1							

DHMH 17 Rev 1/2001 OCME 2006

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760 DHMH 17 Rev 7/2009

			Pleas	e Type or Pr						-		_		
		For State Registrar		State of M	ıaryıan		rtment of tificate of			-	giene Reg. Né	2010	295	545
Dhominin	/	Decedent's Name	e (First, Middle, L	ast)						2. Date of De			3. Time o	
Physicia Medic	al	Earl	Mrtche	11 Jr						Sept.	14	2010		A ^M
Examin	er			ve street and number) Yland Med	val (enter	4b. City, Town	or Location			4c.	County of Deat	h	
Funeral		5. Social Security No	umber 6.	Sek 7. Ag	ge (In yrs. la	ast birthday)	If Under 1 Yes	r If Unde	er 24 Hrs.	8. Date of Bir (Month, Da	th y_Year)	9. Biri	thplace (State of untry) aryland	or Foreign
Director		213-50- Usual Residence of	-5246	1 2 3 W 2 2 1		Yrs.				(Month, Da Nov	05,_	1947 M	arylano	
yland f shov ed at	tor	10a. State	10b. County		10c. City	y, Town or Loc	ation						10d. Inside C	
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with the 23a cust be	eral		nestnut :	Road			212					Jnited S		
death items ner m		11. Marital Status		12. Was Decedent Armed Forces?	_	6. 13. W	as Decedent of Yes, specify Co	Hispanic C ban, Mexic	origin? (Spe an, Puerto	cify Yes or No- Rican, etc.)		14. Race - Ame Black, White		
s after al", or Exami	d by	1 ☐ Never Marri 3 ☐ Widowed		1 Yes 2 If Yes, Give Year or Dates.	No	1	☐ Yes 2 🔀	lo Specii	fy:			Specify:	White	
2 hours "natur dical	Completed	(Spe	15. Decedent's cify only highest of	Education			ent's Usual Occ ind of work dor		ost of worki	na	16b. K	ind of Business	Industry	
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Page ment c ant: If ury or			Cremation 3 5 Other (Spec	☐ Removal from State cify)	'	emetery, crema hesapea		· i	Y	Sep 18 2010	' E	Beltsvil	le, Mary	rland
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur	neral Service Lice	nsee	20	158\$ ^{22.}				eral Al				200
				mplications that cause		n. Do not enter						son Mary	Approxima	te
Physician/	8 19	Immediate Cause (disease or conditio	Final	one cause on each lin		ngui	nati	on					Interval Be Onset and	
Medical Examiner		resulting in death)		Due to (or as		ience df):								
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that the	by Ph	Part II. Other signif	icant conditions	contributing to death	but not res	ulting in the un	derlying cause	given in Pa	rt I.	23e. Did t	obacco u	se contribute to	the cause of c	death?
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ding Pl .r After th funeral		27. Manner of Death 1 Matural	5 Pending	28a. Date of inj (Month, Da		28b. Time of injury		ury at ork? Yes 2		28d. Describe h	now injun	y occurred		
Attendary death	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investigati 6 Could not determine	be 28e. Place of In					□ NO			d Number or Ru	ral Route Num	ber,
ital or irs afte al Dire	al Ce	Tioniodo	dotomino	building, et	c. (Specify) 				City or Tov	vn, State)		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2	Medical Exa	nysician: To the best o	examination	and/or investi	gation, in my op	nion, death	occurred at	the time, date a	and place	, and due to the	cause(s) and ma	anner stated.
To the within To the Comple	Σ	only one) 3 29b. Signature and t		urse Practioner: To the	e best of my	/ knowledge, de		the time, da nse number		e, and due to tr		te signed (Mont		
		16	issu	ws B	u	JMD.	145	7696	193		Sy	Hembe	116,2	2010
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Stat	e	31. Date filed (Month		32. Regist	rar's Signat	ture	1 ITWEL	in a	YVIV	0000	r JUNU	coi, ca	NIVILUIT,	- 1- Z140
Registra	ar	SEP 2	1 2010	Denve	1.	back	,					_		

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

10-069	10
Tracey	Mckay

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Tracey Mckay	Registrar	nt of Health and Mental Hy e of Death	giene 2010 29547
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Tracey Ann McKay		2. Date of Death Month Day Year September 9, 2010 3. Time of Death 0020 hrs
	4a. Facility Name (if not institution, give street and number) Johns Hopkins Bayview	4b. City, Town, or Location of Death Baltimore	4c. County of Death Baltimore
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	yrs. If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country)MA
Maryland 28a-f show any d.at.once. ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or MD Baltimore Baltim		10d. Inside City Limits
the Maryland Sa or 28a-f sh ptifted at once	10e. Street and Number 3407 Foster Ave	10f. Zip Code 21224	10g. Citizen of What Country? USA
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Inst. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes cise Year or Dates:	3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No specify:	
5-0036 ed vithin 72 hours tygiene. the Medical Exam Completed b	Elementary/Secondary (0-12) College (1-4 or 5+) 4 MC	cedent's Usual Occupation (Give kind of wing most of working life. DO NOT use retire the property of the prope	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	17. Father's Name (First, Middle, Last) Henry J. Stelline	Linda	First, Middle, Maiden Surname) a.A.Pesce
, MD 21 and 2 should ealth and Mer tem 27 is man traumatic ev	Linda A. Reardon Mother 33	Budleigh Ave Besisposition (Name of cemetery,	Jerly MA 01915 Date 20c. Location - City or Town, State, Zip Code)
Baltimore, MD 21215 pernit. Pages I and 3 should be file Department of Health and Mental H. Important: If item 27 is marked a injury or other traumatic event, it	1 Burial 2 Cremation 3 Removal from State crematory 4 Donation 5 Other Specify:	or other place)	10/2010 Glen Bernie MD
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not er	ThomasallenPA /	olicity Crem & Fun Serv 090 Ridge RD Hanover MD respiratory arrest, shock, or heart Approximate Interval
/Mii Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Methadone Intoxicat Due to (or as a consequence of):	tion	Between Onset and Death
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury tract initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of):		
execu an and al - tra	IF FEMALE: 23b. Was decedent pregnant in the	,28a-f,perMF,q908,10/	23d. Date of delivery
D. Box 68760, it the death certificate be by the attending physics by the attending physics of the for use as the burn Physician/Med	past 12 months? 1 Yes 2 No 9 ✓ Unknown 1 Unknown	Other (Specify)	- I World Day Teal
P.C es that igned oe det	Part II. Other significant conditions contributing to death but not resulting in Cocaine Use	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✓ Unknown
	25. Was case referred to medical	26.Place of Death (Check or	24a. Was an autopsy findings available prior to completion of cause of death? 1 🗸 Yes 2 No 1 📝 Yes 2 No
f Vita Physicia er this ceral direct	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpa 27. Manner of Death 28a Date of Injury 28b Time	tient 3 DOA Other Nursing	Home 5 Residence 6 Other:
- ± . ≤ai 5i	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	5 hrs 1 Yes 2 X No	8d. Describe how injury occurred subject ingested Methadone 8f. Location (Street and Number or Rural Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	4 Homicide determined (Specify) residence 29a. Certifier 1 Certifying Physician: To the best of my knowledge death of	ccurred at the time, date and place, and d	
To the within To the compl	one) 2 Medical Examiner: On the basis of examination and/or investand manner stated. 29b. Signature and title of certifier	tigation, in my opinion, death occurred at 29c. License number	he time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
	MM ()	O.C.M.E.	September 9, 2010
8	30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD	21201
State Registrar	31. Date filed (Month, Day, Year) SED 2.1.2010 32. Redistray Signature	bares	OOME SWOO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per FH G907 9/2/10 Health and Mental Hygiene amend items 14,22 per fh g908 10-13-10 vt

Certificate of Death

Reg. No. State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month a 25a Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Faw Nowood Ellicott City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. (Month, Day, Year) 0 7 2 9 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Months **Director** Turkey 340-48-6952 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy njury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral U.S.A 3026 Fawnwood Drive 21042 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc.

White Armed Forces?
1 ☐ Yes ※☐ No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) GBMC Hospital 12th grade Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Kamil Oruncak Melahat Oruncak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21042 Sengun O. Nuri-Husband Fawnwood Drive, Ellicott City, 3026 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Memorial Park 9/19/2010 Woodlawn, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, 21215 21042 Mdas Approximate Interval Between Opset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final METASTATIC Physician/ COLON CANCER disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is interested as or injury) Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕅 No
9 ☐ Unknown Month Day Year Pregnant at time of death 5 Other (specify) signed by the a g 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed been si should I 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No After this certificate has funeral director, page 2: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 🖪 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 🖪 Natural injury 5 Pending n 24 hours after death le Funeral Director: A oleted filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 3 [only one) 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year) SEPTEMBER 18, 2010 064931 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID COSGROVE, JOHNS HOPKINS HOSPIMM, GOD NORTH WOLFE STREET, BALTIMORS, ND 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 21 2010 parke Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:45aM Newton 09 2010 Ellen Elizabeth Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Nursing Home Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 👿 F Hours Min. (Month, Day, \ 03 09 Year) Country) Director 80 578-46-2911 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director NA Baltimore 1X Yes 2 ☐ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5103 Oueensburg 21215 U.S.A. Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian. Armed Forces 1 Never Married 2 Married þ Yes 2 No 72 hours after Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: Black "natural", 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates. or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland 2th grade 4yrs Claims Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clvde Blakelv Sadie Blakely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other tra Edgewood Street, Baltimore, Md 21216 Anthony Newton-Son
20a. Method of Disposition Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 9/24/2010 Owings Mills, Md 21. Signature of Funeral Service Licens 22. Name and Address of Facility

arch F/H West

4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examir that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical am Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diseas 1 Yes 2 No 3 Probably 4 Onknown neec 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Was an autopsy performed has funeral director, page 2 Hospital or Attending Physician: The After this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred iniury 1 Natural 5 Pending death. 2 Accident
3 Suicide
4 Homicide Investigation after death filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of certifet 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar SHOAIS

SEP 21

DHMH 17 Rev 7/2009

MD

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAS ITMI

D31464

821 N. GYTAW ST ANTE 308

BALTIMORE MUYZI

10-07044 Mary J. Naylor Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Mary J. Naylor	1	St - For State	tate of Maryla		artment of rtificate of		Mental H		2010	29550
Physician	F	legistrar 1. Decedent's Name (First, Midd	dle,Last)		tineate of	Douth		2. Date of Death		3. Time of Death
Medical Examine	er	MARY JAN	XE NAYL			b. City, Town, or Lo	agation of Dooth	Month September	Day Year r 13, 2010 4c. County of Dea	0810 hrs
		4a. Facility Name (if not institution Frederick Memorial H		ımber)	4	Frederick	ocation of Death		Frederick	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24Hrs	8. Date of Birtl	h(MM/DD/YYYY) 9. B Fore	irthplace (State or
Director		215-46-1818	1 M 2 F	65	Yrs.	Months Days	Hours Min	MAR.	18,1945 C	ountry) MD.
ri,	-	Usual Residence of Decedent 10a, State 10b, County		10c. City,	Town or Location	on				10d. Inside City Limits
nd show a	_	MD. FREI	DERICK	WA	ALKER	SVILLE				1 Yes 2 No
Maryla: 28a-f: d at on	Ulrector	10e. Street and Number	2 / 5 /	-		10f. Zip Code	107	10	lg. Citizen of What Co	untry?
Imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Instit (Fitem 27) is marked other than "matural", or items 23a or 28a-f show any or other traumstic event, the Medical Examiner must be notified at once.	<u></u>	8796 DA		cedent Ever in U	S 13 W/as	217 Decedent of Hispa		necify Yes or No-		rican Indian, Black,
eath wirtems	Funeral	1 Never Married 2 M			If Ye	s, specify Cuban, I	Mexican, Puerto	Rican, etc.)	White, etc.	
after d	<u>-</u>	3 Widowed 4 Div	vorced If Yes, Give Yea			Yes 2 No			Specify: BL	
hours natur		15. Decedent's Education (Spe				s Usual Occupatio st of working life. [and\	16b. Kind of Business PRIVATE	/Industry
136 hin 72 e. than "	Completed	Elementary/Secondary (0-12)) College (1-4 or 5+)	CHIL	D CARE	PROVI		FAMILIE	S
21215-0036 uld be filed within 7 Mental Hygiene Marked other than ic event, the Medica	5	17. Father's Name (First, Middle			L			(First, Middle, M		
121; d be fill ental F arked arked vent, j	8	CLARENCE			T401 14 17			1 LYLC	ber, City or Town, Sta	a Zia Cada)
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other injury or other traumatic event, the Med	۱-	19a. Informant's Name/Relations JAMES C.		(SP)						MO 21701
e, M 1 and 2 Health item 2		20a. Method of Disposition		20b. I	Place of Disposi	ion (Name of ceme	etery,	Date	20c. Location - City of	r Town, State
MOF Pages ent of nt: If	- 1	1 Burial 2 Cremation 4 Donation 5 Other S		rom State	ARVIEU	u (EM.	StPi	7 20,20	10 FREDE	RICK MD
Baltimore, MD remit. Pages I and 2 sho Department of Health and misportant: It item 27 in injury or other traumati	T	21. Signature of Funeral Service	e_Licensee	.1	22. N	ame and Address of	of Facility GA	RYL. RE	DLUNSFL	RICK MD NI HOME 21701 Approximate Interval
	4	July X /		aused the death	. Do not enter th	e mode of dving, si	uch as cardiac o	r FREDE	St, shock, or heart	Approximate Interval
Physician /Medical		failure. List only one cause Immediate Cause (Final disease	e on each line.			vascular Dise				Between Onset and Death
Examiner		or condition resulting in death)		consequence o						
		Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequence o	f):					
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uted nd ransit	Ž	events resulting in death) Last	d	consequence o						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - transit	g	UNPENDED	AMENDED							
Box 68760 e death certificate be the attending physi ed for use as the bu		F FEMALE: 3b. Was decedent pregnant in t		outcome of preg	-	al death 3	Ectopic pregna	ancy	23d. Date of delive Month	ry Day Year
ox 60 at the cert attendir or use a	Sicia	past 12 months? 1 Yes 2 ✓ No 9 Un	diamenta -	nant at time of de	oth =	er (Specify)				
O. BC trihe dez by the a	ڇَا	Part II. Other significant condi	9 UNKII		esulting in the ur	nderlying cause giv	ven in Part I.	23e. Did tol	bacco use contribute t	o the cause of death?
Division of Vital Records, P.O. Brat or Attending Physician: The law requires that the data faste death. The law requires that the data been signed by the led in by the funeral director, page 2 should be detached the corrections.	2		_					1 Yes	2 No 3 Pr	obably 4 🗸 Unknown
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Vital Records, ysician: The law requil his certificate has been idirector, page 2 should	Completed							perform 1 ✓ Yes 2		
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f Vid	٥L	1 Yes 2 No 27. Manner of Death	Hospital: 1	Inpatient 2 🗸	ER/Outpatient 28b. Time of In	<u> </u>			Residence 6 Oth	er:
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ViSic or Atte fler deg Directo	Certification:		estigation 28e. Plac	ce of Injury - At h	ome, farm, stree	t, factory, office bui	ilding, etc.	28f. Location (S or Town, St		tural Route Number, City
Di Spital o nours al	5 2	4 Homicide dete	ermined (Specify)							
Division of N To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	<u></u>	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	aminer:On the basis	of examination a	ge, death occurr ind/or investigati	ed at the time, date on, in my opinion, o	e and place, and death occurred a	I due to the cause at the time, date a	e(s) and manner as sta and place, and due to	ated. the cause(s)
To To com	Mec	29b. Signature and title of certifi	and manner s	stated.	/	29c. License	number		29d. Date signed (M	onth, Day, Year)
		(all 1	111	1/1	1	O.C.M	I.E.		September 14,	2010
	t	30. Name and address of person				n Street, Baltin	nore MD 31	201		
Sto	to		Assistant Medic			- Sueet, Daitin	ZI	201		
Stat Registra	ar	SEP 2 1 2010	Denous	egistrar Signat	are					

DHMH 17 Rev 1/2001

ORIGINAL

OCME

10-07100 Erik Bengt Norbeck

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Medical Examiner 0831 hrs Erik Bengt Norbeck September 15, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5924 Thunder Hill Road Howard 5. Social Security Number if Under 1 Year 7. Age (In yrs. last birthday) If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Min. Director Unk Country) CA 03/01/1957 1 M 2 F 53 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Howard 28a-f show Columbia 1 Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho finjury or other traumalic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5724 Thunder Hill Rd. 21045 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 Married 1 Yes White 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Variety Technician 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Bengt T. Norbeck Beverly Ekman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Norbeck/Mother 5724 Thunder Hill Rd. Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 21 crematory or other place) Sept. 1 Burial 2 Cremation 3 Removal from State Beltsville, MD Chesapeake Crem. 2010 4 Donation 5 Other Specify: 22. Name and Address of Facility CAFA/Stephen D. Lohrmann P. A 21. Signature of Funeral Service Licensee Pastures Dr. Balto, MD 21286 8717 Green Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician failure. List only one cause on each line. Between Onset and /Medical Death a Upper Gastrointestinal Hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Cirrhosis of Liver Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical X UNPENDED AMENDED #23a,b,perME,G907,9/28/2010,WS Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the attending por use as the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown i signed by the a 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other: A Nursing Home 5 Residence 6 Other: Scene DOA 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1 X Natural 1 Yes 2 No death. Director: 2 ___ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Hallow 1 de O.C.M.E. September 16, 2010 30. Name and address of person who completed cause of death (Item 23a)

State Registrar

Carol Allan, MD

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene.

			1 - For State Registrar	State of Maryland		artment of t tificate of t		Mental Hy	giene Reg. No.	2010	29552
	Physicia		1. Decedent's Name (First, Middle, Las Raymo		l Sr			2. Date of De		.6 2ď ľo	3. Time of Death 5:00 p M
	Medi Examii		4a. Facility Name (if not institution, give	street and number)	, 51.		or Location of Deat			County of Death	3.00 p ™
	Funeral	7	2823 Georgetown 5. Social Security Number 6. S	ex 7. Age (In yrs. la:	st birthday)	Baltim If Under 1 Year	If Under 24 Hrs		th	N/A 9. Birthp	lace (State or Foreign
	Director		217-07-6108 ¹ Usual Residence of Decedent	XIM 2 □ F 91	Yrs.	Months Days	Hours Min	Feb. 1	3, 19	919 Mar	ÿ land
	yland -f show ed at	ctor	10a. State 10b. County		Town or Loc					1	0d. Inside City Limits
	the Mau or 28a e notifi	Director	Md. N/A 10e. Street and Number	Ва	ltimor	e 10f. Zip Code			10a. Citiz	zen of What Coun	1 X Yes 2 □ No
	ith with ms 23a must b	Funeral	2823 Georgetown		T	2123				US	
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	 12. Was Decedent Ever in U.S. Armed Forces? 1 XI Yes 2 □ No If Yes, Give Year or Dates. 	1	☐ Yes 2 🕅 No		pecify Yes or No- to Rican, etc.)		4. Race - America Black, White, e Specify: White	tc.
215-	in 72 ho e. nan "na Medio	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)		(Give k	ent's Usual Occup ind of work done O NOT use retired)	during most of wo	rking	16b. Kin	nd of Business Ind	lustry
d 21	ed with Hygien other the	Be C	8 17. Father's Name (First, Middle, Last)		Maint	enance	Worker	me (First, Middle,		SFG	
ylan	ld be fil Mental larked atic ev	2	Thomas Noratel						rseke	•	
	12 shou lith and 27 is m r traum		19a. Informant's Name/Relationship (T) Dorothy Lowe/ Da				and Number or Ru				
Baltimore,	je 1 and t of Hea lf item or othe		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗔	20b. Pla	ace of Dispos metery, crem	sition (Name of	ce)	Date	20c. Loc	cation - City or To	wn, State
altim	nit. Pag artmen ortant: injury		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licens	w) More	eland	Mem. Par	k 9-2	0-10		timore,	
Ä	permit Depar Impor any in			list	()	1 1	uck Tows 050 York	on Funer Rd. Tow	al Ho son,	ome, inc Md. 2120	54
d	Physician, Medical Examiner		23a. Part 1. Enter the disease, or come shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseque	y &		ng, such as cardiad			3	Approximate Interval Between nset and Death
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseque	ence of):		_				
of Ci	cate be executed physician and the burial-transit	Exam	Cause (Disease or linjury that initiated events resulting in death) Last	c	ence of):		··				
3760	ficate be executed physician and is the burial-transi	dical	C	d							
. Box 687	To the Hospital or Attending Physician: The law requires that the death cartifical within 24 hours after death, within 24 hours after death, to the Funeral Director. After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of pregnan- 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 🗌	Ectopic pregnand Other (specify)	су		23	3d. Date of delive Month	ry Day Year
, P.O.	es that tigned b	by P	Part II. Other significant conditions co	entributing to death but not resul	ting in the ur	nderlying cause gi	ven in Part I.	100		e contribute to the	1
ords	v require been s should	oleted						1 W			ably 4 Unknown
Rec	The law cate has page 2 a	Comp						auto		prior to con death? 1 ☐ Yes	npletion of cause of
Vital	/sician: s certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ E	P/Outpotions	Oth	ace of Death (Che			700 70 70	
Division of Vital Records,	ling Phy I. After thi funeral (27. Mann of Death 1 Vatural 5 □ Pending		8b. Time of injury	28c. Injur	y at	28d. Describe h		Other (Specify) occurred	
ision	• Attencer death • ector: / by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom	ie, farm, stre		Yes 2 □ No			Number or Rural I	Route Number,
Ο̈́	pital or ours aft eral Dir filled in		29a. Certifier 1 Certifying Phys	building, etc. (Specify)	da . Leab -	I data the		City or Tow			
	the Hos nin 24 h the Fun npleted	Medical	only one) 3 Certifying Nurs	ner: On the basis of examination a e Practioner: To the best of my le	and/or investi	gation, in my opinic	on, death occurred	at the time, date a	nd place, a	and due to the caus	se(s) and manner stated.
	North		29b. Signature and title of certifier	aun		29c. License	number		29d. Date	signed (Month, D	ay, Year)
	(x)	ŀ	30. Name and address of person who co	ompleted cause of death (Item 2	(3a) (Type, Pr		MOV -0	GTT :	20	Calari	2010
	Stat	C	31. Date file prop th Day, 197110	32. Registrar's Stratu	SE M	VKINIM.	APX DR	-,STEI	10	GUEN 1	outh (FM)
	Registra	ır	GE: & I 2010	range p. 1	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Septemon 2010 Medical la. Facility Name in not institution, give street and number Examiner 4b. City Town, or Location of Death 4c. County of Death Rockville Montgomeri ventis 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, If Under 1 Year If Under 24 Hrs. . Social Security Number 9. Birthplace (State or Foreign Funeral Min. Hours 1 🗆 M 2 🖼 2010 Director Usual Residence of Decedent shov 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director or 28a-f Montgomer 10e. Street and Numbe 10f. Zip Code SEP TEMBER 10g. Citizen of What Country? or items 23a Completed by Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married 2 No Yes Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) PALMER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 1919 line GEORGIA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Location - City or Town, State 1 Neurial 2 Cremation 3 Reprioval from State 4 Donation 5 Other (Specify Funeral Service 22. Name and Address of Facility Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ CARDIO PULMONARY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner YPOTENSION Sequentially list conditions, if any, leading to ministrate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for se a consequence of or Attending Physician: The law requires that the death certificate be executed use as the burial-transit CLOSTRIDIUM DIFFICILE that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Dav 5 Other (specify) 1 ∐ Yes ∠ ⊑ 9 ☐ Unknown should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has performed?. Yes 2 XNo 1 Yes 2 No **Division of Vital** within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 XNo Other: 2 1 Inpatient 2 ... ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifi SEPTEMBER 14, 2010 D0067512 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Time of Death

1 Des 2 De

Year

20 M

Registrar DHMH 17 Rev 7/2009

State

's Signature

9901 MEDICAL CENTER DRIVE

ROCKVILLE

BANGALORE

MD

32. Regian

MADAN

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month George Dawson Parlett 8:10 2010 Medical ept 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Agnes HOSPITA BALTIMORE Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 ★ M 2 □ F Davs Months April 4, 1911 216-09-2512 99 Hours Director Yrs Maryland Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location notified at Director 10d. Inside City Limits 28a-f MD. 1 Yes 2X No Baltimore Catonsville 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a with 719 Maiden Choice Lane Apt.BR 433 21228 United States items death \ 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married ģ 1 Yes 2 X No
If Yes, Give
Year or Dates. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. item 27 is marked other than "natural", or other traumatic event, the Medical Examii Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Pharmacist Healthcare Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked out any Injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ည Albert Haratio Parlett Mary Joseph Dawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude Parlett/Wife 719 Maiden Choice Lane Apt.BR 433 Catonsville,MD21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory, LLcSept 18 2010 Glen Burnie, Maryland 1 Burial 2 T Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ure of Funeral Service Licensee 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Immediate Cause (Final Onset and Death Ph sician/ PHEUMONIA disease or condition resulting in death) OURS/PAYS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical signed by the attending place as it be detached for use as IE EEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by TRACT INFECTION Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should ACUTE INSUFFICICIO RENAL 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has DEMENTIA performed? Yes 2 No 2 X No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to Division of Vital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 \square Pending injury 2 Accident 3 Suicide Investigation 1 Tes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 7/2009

State Registrar

1

900 S. caton

Ave.

BALTIMORE, MD 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gruma

M.D

channarose

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29555 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0 Month 2010 17 2:00p. M D. Pinkney Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3502 Dennlyn Road <u>Baltimore</u> **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Months Hours Min. 1 M 2 X F Director 77 20 30 - 7350show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director MD NA Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3502 Dennlyn Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. Be Completed by 1 Never Married 2 Married 2 X No ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: 3 Divorced 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>12th grade</u> 6yrs+ City Hospital Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Madeline A. Craig James S. Pinkney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6201 Robin Hill Road, Baltimore, Md 21207 Christine Tucker-Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn 9/23/2010 Woodlawn, Md tur of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Sig Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Retween Onset and Deat lediate Cause (Final Physician/ SouAmous CANCER CELL isease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Esquentially for conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No ate has been signed by the atte page 2 should be detached for 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No within 24 hours after deam.

To the Funeral Director: After this certificate I

manufered filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical B B 26. Place of Death (Check only one) Hospital Other: မ 1 L Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending iniurv work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) MA D 16**3**54 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OCE AGNES 900 CATON BALTIMORE

/DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 29556 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Robert S. Piasecki 12:37 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Kosedale Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Country) MA Aug. 1, 1935 015-26-2930 1 🖾 M 2 🗆 F Months Days Min **Director** Usual Residence of Decedent or items 23a or 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a, State 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Middle River 1 🗌 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 827 Thimbleberry Road 21220 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 9 1 Never Married 2 Married 1 ★ Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify: 3 Divorced Completed White permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Meat Cutter Shoppers 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Stephen Piasecki MArgaret Fitzgibons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Violet Piasecki /wife Thimbleberry Road Balto. MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Kerrial 2 Cremation 3 Removal from State Holly Hill Cemetery 9/24/10 Baltimore MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Funeral Home of Essex Connelly 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a sequence of): **Examiner** Sequentially list conditions, if any, each grown in mediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months? Month Dav Year certificate has been signed by the a irector, page 2 should be detached Completed by Be မှ this Certificate:

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 completed filled in by the funeral director, 24 hours within 2

ho / A S EC K $^{'}$. Baltimore, Maryland 21215-0036

g Unknown	9 🗆 Unknown	(-),		
	contributing to death but not resulting in the under			obacco use contribute to the cause of death? Yes 2 \(\subseteq \text{No} \) 3 \(\subseteq \text{Probably} \) 4 \(\subseteq \text{Unknown} \)
			24a. Was auto perfo 1 \(\sum \) Yes	
25. Was case referred to medical examiner?		26. Place of Death (Chec	ck only one)	
1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	□ DOA Other: 4 □ Nursing H	ome 5 Resi	dence 6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio		28c. Injury at work?		now injury occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (\$ City or Tov	Street and Number or Rural Route Number, vn, State)
(Check 2 \(\subseteq Medical Exam	sician: To the best of my knowledge, death occur iner: On the basis of examination and/or investigation se Practioner: To the best of my knowledge, death	n, in my opinion, death occurred a	at the time, date a	and place, and due to the cause(s) and manner stated
29b. Signature and itle of certifier		29c. License number		20d Date Figured (Month Day Year)

1006

29d. Date ≸igned (Month, Day, Year)

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101

State Registrar

Medical

SEP 21 2010

os of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 29557 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 12, 2010 Margarete W. Pate 10:10 AM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🗓 F Months Hours Min. 578-48-0719 81 Yrs. October 29, 1928 Germany Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Silver Spring 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11803 Selfridge Road 20906 United States Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. 1 Yes 2 X No Specify: 3 Midowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Otto Wilhelm Maria Jutz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Pate / Son 15315 Straughn Drive, Laurel, Maryland 20707 20a, Method of Disposition 20b. Place of Disposition (Name of Sept. 18, 2010 20c. Location - City or Town, State 1 Burial 2 XI Cremation 3 Removal from State cemetery, crematory or other place) Montgomery Crematorium, Inc 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signature of Fuyer Jervige Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Pact / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Gastric Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Dause (Disease or iirijury that initiated events resulting in death) Last Due to (or as a consequence of)

Physician Medical Examiner

Physician/

Medical

10a. State

Examiner

Funeral

Director

within 72 hours after death with the Maryland

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permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, #

Baltimore, Maryland 21215-0036

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er than "natural", or items 23a on the Medical Examiner must be

Director

Funeral

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Completed

Be

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Examine Be Completed by Physician/Medical

and I-transit attending physician a for use as the burialbeen signed by the sale page funeral director, Certificate: To

	d	
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical examiner?	26. Place of Death (Chec	k only one)
1 ☐ Yes 2 🂢 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	ome 5 Residence 6 X Other (Specify) Hospice IPU
27. Manner of Death 1 🕅 Natural 5 🗆 Pending 2 🗀 Accident Investigation 3 🗆 Suicide 6 🗀 Could not be	28a. Date of injury (Month, Day, Year) 28b. Time of injury work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred
4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

1355 Piccard Drive, Rockville, Maryland 20850

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Dav. Year)

September 13, 2010

29c. License number

D37142

10 V

Hospital or Attending Physician: The law requires that the death certificate be executed

this certificate has

n 24 hours after death.

ne Funeral Director: After the pleted filled in by the funeral

within 2 **To the I**

Medical

29a. Certifier

3 🗌 29b. Signature and title of certifier

Coleman, MD

SEP 2 1 2010

31. Date filed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print)

Division of Vital Records, P.O. Box 68760

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20b,22 per th g907 9-21-10 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month G Year **Physician** 04:35 A M AKER 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BaltiMore 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Yea) 7. Age (In yrs. last birthday) If Unde Birthplace (State or Foreign Country) 6. Sex **Funeral** 12 M 2 □ F Director death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show 1 ☐Yes 2 No OWSON ns 23a or 28a-f sh must be notified **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify Specify: Completed by 3 Widowed 4 □ Divorced artment of Health and Mental Hygiene. ortant: If item 27 Is marked other than "natu Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) wner ラナ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) virn and Mental H. Be ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Delationship (Type. Print) 17d 20a. Method of Disposition
1 ☐ Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 3 Demoval from State Department o Important; If any Injury or once. 5 ☐ Other (Specify) 4 Donation Name and Address of Facility Greene Cremation 21. Signature #uneral sarvi icensee MO 155 119-121 S. Stricker St. Balto. Md. 21223 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EMENTIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Be Completed by 3 Probably 4 Unknown 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1☐ Yes 2☐No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 No Medical Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1-Natural 5 ☐ Pending investigation Injury 1 🗌 Yes 2 🗌 No 24 hours after death.

Funeral Director A 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide + Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only within 24 To the F and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN 10064533 Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) LEVIND ALE GENIATRIC CTIL 3 AJANI 2434 W. BELVEDERE AVENUE BALTIMORE BUBATUNDE M 31. Date filed (Month, Day, Year) State 21 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 02:65 AM Robert B. Ridgley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MOSPIta Saltme Vai. 01 Immure 8. Date of Birth (Month Day, Year) 1/7/1948 Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral Days 1 🕱 M 2 🗆 F Months 62 Director 215-50-5658 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Examiner must be notified at Director 1 Yes 2XNo MD Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Completed by Funeral USA 21157 4514 Salem Bottom Rd. is marked other than "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ☐ Yes 2 🔼 No Black, White, etc 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Maryland 21215-0036 If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NIH 12 Pipe Fitter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Leona Klingelhofer P. Brooks Ridgley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4514 Salem Bottom Rd., Westminster, MD 21157 Suzanne Ridgley/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State <u> Evergreen Mem. Gardens 9/24/2010</u> Donation 5 Other (Specify) Finksburg, MD of Funeral Service Licensee Sidnature ²² Burrier Queen Funeral Home & Crematory, 1212 W. Old Liberty Rd., Winfield, MD 21784 23. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im rediate ause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death 2 No 1 ☐ Yes 2 L 9 ☐ Unknown a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes ②X No 3 ☐ Probably 4 ☐ Unknown After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2/No 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Tes Appatient 2 ER/Outpatient 3 DOA 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year) SEP 2 1 2010

DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 9:40 AM September Karl Ritums Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3922 Beech Ave. Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Months Days Hours Min Latvia 1 M 2 🗆 F 90 Director 159-28-0445 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 ¥ Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21211 3922 Beech Ave 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖂 o Specify: 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Social Security College (1-4 or 5+) Elementary/Seconday (0-12) Auditor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Emilija Tamsons Adam Ritums 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Helena Ritums /Wife 3922 Beech Avenue Baltimore, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 remation 3 Removal from State Sep 1 4 Donation 5 Other (Specify) Beltsville, Maryland $20\overline{10}$ Chesapeake Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility M0144 Cremation and Funeral Alternatives land 21286 Green Pastures Drive Towson 9717 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medica resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to jor as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or iinjury that initiated events resulting in death) Last as the burial-transit attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: esn 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death been signed by the should be detached 1 ☐ Yes 2 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed Yes 2 After this certificate has 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation after deat Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29c. License number 0025 2010

State Registrar

30. Name and address of per-

31. Date filed (Month, Day, Year) SEP 2 1 2010

Grea

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 737 Physician/ 2010 09 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** N/A If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex 1 X M 2 □ F Age (In yrs. last birthday) Funeral (Month Day, Months Hours Min. ^{*}1960 Delaware 50 Yrs. 221-46-5959 **Director** Usual Residence of Decedent 10d, Inside City Limits 28a-f show 10a. State 10c. City, Town or Location at Director "natural", or items 23a or 28a-f s 1 Yes 2X No Millsboro Delaware Sussex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 19966 28385 Roberta Lane 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 Never Married 2 X Married þ Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Appliance Sales Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carol Wood ဂ္ Clark Stanley Sheldon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 28385 Roberta Lane Millsboro, DE 19966 Joan C. Sheldon, Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of harmonic of harmonic line any injury or other 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland 09/17/10 Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician a sthe burial-23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Month in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗆 No Yes 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: 1 Natural 5 Pending work?
1 Yes 2 No М ☐ Accident ☐ Suicide Investigation Could not be after death

Director: A 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Box 68760 Division of Vital Records, P.O. within 24 hours a To the Funeral C

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

Sarah

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ September 20, 2010 8:18 P M Edward Schultheis, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 1207 River Road Linthicum Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 🕅 M 2 🗆 F Jul v 28 1930 Marvland Director 220-24-9936 80 Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director MD Anne Arundel Linthicum 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a1207 River Road 21090 USA or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 XMarried ò Yes Yes, Give 2 **X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the Construction Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Phillip Schultheis Erma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loretta M. Schultheis, wife 1207 River Road Linthicum, MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If it any injury or o once. tment of 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 09/21/10 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD. 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between
Sonset and Death
Month Immediate Cause (Final Mesofuliama Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Vear Pregnant at time of death Yes 2 No the g 🗌 Unknown 9 Unknown þ signed b Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Director: After this certificate has autopsy performed: death? 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **W** No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral L Medical Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 5. Harover

September 21, 2010

MD 21225

St. Baltimore

nuemo

Young
31. Date filed (Month)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph	F.	Sweeney	

Physician/ Medical Examiner Joseph F. Sweeney. 4a. Facility Name (if not institution, give street and number) 3003 Guilford Avenue Funeral Director Director Director Physician/ 1. Decedent's Name (First, Middle, Last) Joseph F. Sweeney. 4b. City, Town, or Location of Death Baltimore 4c. County of Death Baltimore 4c. County of Death Baltimore 1. Date of Birth (MM/DD/YYYY) 4c. County of Death Baltimore 5. Social Security Number 2. Date of Birth (MM/DD/YYYY) 4c. County of Death Baltimore 1. Day Hours Min. June 7, 1950 Man Baltimore	irthplace (State or Foreign ountry) ryland 10d. Inside City Limits 1 Yes 2 No
4a. Facility Name (if not institution, give street and number) 3003 Guilford Avenue 5. Social Security Number 219-56-4887 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Baltimore 4b. City, Town, or Location of Death Baltimore 4c. County of Death Baltimore	irthplace (State or Foreign ountry) ryland 10d. Inside City Limits 1 Yes 2 No
Director 219-56-4887 1 X M 2 F 60 Yrs. Months Days Hours Min. June 7,1950 Usual Residence of Decedent 10a. State 10b. County Md. Baltimore	ountry) ryland 10d. Inside City Limits 1 Yes 2 No
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Baltimore	1 Yes 2 No
White, etc. The standard of	white White S/Industry
20c. Location - City of Cremation 3 Removal from State crematory or other place)	or Town, State
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Ho	d. 21236
Physician Medical Examiner 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause. (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): UNPENDED AMENDED	Approximate Interval Between Onset and Death
The past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown 23d. Date of delivery Month	Day Year
1 Yes 2 No 3 Pr 1 yes 2 No 3 Pr 24a. Was an autopsy prior to a group of performed performed performed performed performed performed?	obably 4 Unknown autopsy findings available completion of cause of
The state of Death (Check only one) 25. Was case referred to medical examiner? 1 Yes 2 No 1 Section 1 No 1 Section 2 Section 2 Section 2 Section 2 Section 3 Section	ier. Scene
Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or For Town, State)	Rural Route Number, City
4 Homicide determined (Specify) 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as st one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (No. 2)	the cause(s)
296. Signature and title of certifier 296. License number 296. License number 297. License number 297. License number 298. September 17,	
30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Resistrar's Signature	

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend item 4c per dyr g907 9-21-10 vt State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sept. 1 Pay 20 1 0 Anelda Sappington 09 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of DeathArundel **Examiner** Anne Arundo 647 Riverside Drive Pasadena 8. Date of Birth
(Month, Day, Year)
June 26 Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 M 2 52 F Months Director 216-16-3942 87 Yrs 1923 MD Usual Residence of Decedent shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 647 Riverside Drive 21122 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ ☐ Yes 2 🛣 No FYes, Give within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: "natural" 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Collections Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar Schevdt Ida Meyers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David R. Sappington (spouse) Riverside Drive, Pasadena, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept Pate 18 1 Durial 2 Dremation 3 Removal from State Metro Crematory Inc. 4 Donation 5 Other (Specify) 2010 Baltimore, Maryland 21. Signati of Foneral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, dause on each line. 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Dement disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sician and burial-transit Exami Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 month Day Month Year ed by the a 1 ☐ Yes 2 ☐ Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 V No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 🗌 Yes 2 🔲 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 🔲 Yes 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral (27. Manner of Death 28a. Date of injury 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral (Month, Day, Year) 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

025654

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my

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29565 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Katherine Elizabeth Sickle SEPTEMBER 15 th 2010 7:35 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE AGNES If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Jume Pay, Year 31 Marviand 1 M 2 T 217-26-3961 79 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State should be filed within 72 hours after death with the Maryland and Mental Hygiene. Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 x No MD Baltimore Lansdowne 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 3209 Hilltop Avenue 21227 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. item 27 is marked other than "natural", or other traumatic event, the Medical Examin 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine (unk) William Herlth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Belvedere Avenue Glen Burnie MD 21061 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum William Sickle / Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition 1 Durial 2 X Cremation 3 Removal from State Atlantic Crematory \$ept 18, 2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home of Lansdown 20 lm 2719 Hammonds Ferry Road Landsowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEART FAILURE Physician/ CONGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CARDIOM YOPATHY DILATED Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown signed by the at d be detached for 1 ☐ Yes 2 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Records, CHRONIC ORSTRUCTIVE PULMONARY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 🗌 Yes 2 🜠 No certificate Yes 2 X No Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital or Attending Physician: director, Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: ပ 1 🗌 Yes 2 **X** No 1 X Inpatient 2 - ER/Outpatient 3 - DOA this funeral 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of ō Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1006586 M D eotember 15, 2010

DHMH 17 Rev 7/2009

State Registrar kar's Signature

2717 Hammonds Ferry Road Baltimore, m. 21227

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hasan Awan

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#5 per FH, G907, 9/21/2010, WS
State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Z 2. Date of Death 1. Decedent's Name (First, Middle, Last) 50 pt 8:04AM Physician/ 2 DID Elaine 9 Medical 4a. Facility Name (if not institution, give street and num 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bothmore Maryland General Hospital Baltimore If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Month, Day Days Hours Min. Country) 1 M 2 KF Yrs. **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 23a or 28a-f sho important: If item 25a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 X Yes 2 ☐ No Hartford CT NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 06112 100 Canterburg Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces ģ 1 Never Married 2 Married 1 Yes If Yes, Give 2 🗴 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of Connecticut Vice Principal 6vrs+ 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thelma Ellis Albert Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Md 21217 Tanya L. Sharpe-daughter Linden Ave, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Windsor, CT 9/25/2010 Laurel . Sign ture of Funeral Service Licensee 22. Name and Address of Facility
Carmon Funeral Home
301 Country Club Ro mal Country Club Road, 06001 Approximate Interval Between at and Death at 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. 23a. Pa Immediate Cause (Final disease Chronic Physician/ obstructive disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner O eeus heen Sequentially list conditions, Examine as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury eows stage use as the burial-transit and that initiated events Due to (or as a conse resulting in death) Last the attending physician earc restension Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be fain 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Por Day 4 Pregnant : Pregnant at time of death **To the Funeral Director.** After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy death? 1 ☐ Yes 2 ☐ No 1 Yes 2 N 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 EB Outpatient 3 IDOA ျ 2 No 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury_at 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29d. Date signed (Month, Day, Year) 29b. Signature nd title of certifie 2010 30. Name and address of person who completed cause Willams, N of death (Item 23a) (Type, Print) South 31. Date filed (Month, Day, Year) trar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	laryland /		ment of F icate of E		Mental Hy	giene Reg. No	Z U I U	29567	
	Dhusisis		Decedent's Name (First, Michael Control of the	outo or E	2. Date of			Death 3. Time of De					
	Physicia Medic		Josephine Anna Marie Sadilek September 18, 2010 8									8:09 P M	
	Examir	er	4a. Facility Name (if not institu			4b		Location of Deatl	٦		County of Deatl		
	Funeral		5. Social Security Number		je (În yrs. last bii			If Under 24 Hrs.	8. Date of Bir	th		nplace (State or Foreign	
	Director		216-40-6332	1 □ M 2 😿 F	92	Yrs.	onths Days	Hours Min.	(Month, Da June 1	y, Yea <i>r)</i>		ntry) aryland	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	١	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits	
		rect	MD Prin	nce George's	Laur	cel						1 X Yes 2 No	
		alD	10e. Street and Number		10f. Zip Code					10g. Cit	izen of What Co	untry?	
		Funeral Director	14200 Waggar 11. Marital Status	nan Avenue				20707 Vas Decedent of Hispanic Origin? (Specify Yes			USA_ 14. Race - Amer	ioon Indian	
36		þ	1 Never Married 2 1	Armed Forces? 1 ☐ Yes 2 ☐	Armed Forces? 1 ☐ Yes 2 ဩ No			f Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			Black, White, etc.		
Maryland 21215-0036		Completed	3 Widowed 4 Divon	Year or Dates.	Year or Dates.						Specify: White		
215		mpl	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) College (1-4 or 5+)						king	16b. K	ind of Business I	ndustry	
2		Be Co	7th Ø Waitress						Restaurant				
and		To B	M. Guille I						Name (First, Middle, Maiden Surname)				
ary		Mary Sadilek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town,									Code)		
			Michael L. Bo	zievich/Son_		4200		an Avenu		rel,			
lore				ion 3 Removal from State	20b. Place of cemeter	of Dispositio ery, cremato	n (Name of ry or other place	e)	Date	20c. Lo	ocation - City or	Town, State	
Baltimore,		W	4 Donation 5 Othe		West		el Crem		3/2010		enton, N		
Ba		k 7/	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A 313 Talbott Avenue, Laurel, MD 20707										
	Medical Examiner the private physician and the burial-transit		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw.										
		i di	Immediate Cause (Final disease or condition resulting in death)	a	tic Sho							Onset and Death	
5			rosalang in doddin		a consequence iration	•	monia						
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0		Sequentially list conditions, b. Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
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.89 x	e death cert the attendin thed for use	ian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth	2 Fetal deat	Fetal death 3 Ectopic pregnancy					23d. Date of deli	·	
. Box		Physician/N	1 Yes 2X No 4 Pregnant at time of death 5 Other (specify) 9 Unknown								Month Day Year		
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ds,	quires en sig ould b	ted									es 2 🗓 No 3 🗌 Probably 4 🗎 Unknown		
Records,	law re has be e 2 shi	Completed	24a. Was an autops performed?							prior to c	b. Were autopsy findings available prior to completion of cause of death?		
R	n: The la ficate ha ir, page ;		25. Was case referred to medic	cal T					1 🗆 Yes			2 X No	
of Vital	ysicia is cert direct	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ER/O	utpatient 3	Othe	r: 4 Nursing H		dence 6	Other (Specific	(v)	
of			27. Manner of Death 1 X Natural 5 □ Pen	28a. Date of inju	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 Yes 2 No					28d. Describe how injury occurred			
sion		Certificate:	2 Accident Inve	estigation uld not be									
Division			4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		Medical	29a. Certifier (Check 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									ause(s) and manner stated.	
	o the vithin 2 o the	ž	only one) 3 Certifying Name Practioner To the best of my knowledge death occurred at the time date and place, and due to the cause(s) and name at 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon.) and mainter as t	tated		
			1 Nean A	i Mh			D6943			091	18/ 20		
	101		30. Name and address of person	on who completed cause of d	eath (Item 23a)	(Type, Print)		1 /	Α.				
	Stat		Nega Ali (31. Date fi (Month, Day, Year	Gosi , 7300	Van ar's Signature	Dus	en Ra	ad, L	aurel	M	5 207	W+	
	Registra	-	CED 0 1 2010	hand &	back								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State		State	of Maryla				nd Mental H	ygiene	010	29568	
			Registrar 1. Decedent's Name	Last)	Cel	tificate of L	2. Date of D	Reg. No	010					
	Physicia	nysician/									ber 175,	. 2010	3. Time of Death 5:08 p M	
		Examiner 4a. Facility Name (if not institution, give street and number)							4b. City, Town, or Location of Death			4c. County of Death		
-	<u> </u>	Gilchrist Center						Towson		Baltimore				
amoral . V					7. Age (In yrs.	ge (In yrs. last birthday) 72 If Under 1 Year If Under 2 Months Days Hours			Min. 8. Date of B	8. Date of Birth (Month, Day, Year) Sept 8, 1938 9. Birthplace (State Country) Mary				
			Usual Residence of	Decedent						Sept 0	, 1950			
	ıryland a-f she ied al	ctor	10a. State	10b. County			City, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 🗓 No	
	he Ma or 28a e notif	Dire	MD 10e. Street and Nur	Baltin nber	iore	[1111	onium	10f. Zip Code			10a, Citizen	of What Cou		
	s 23a ust b	Funeral Director	16 Spyg	lass Co	urt			21093			USA		,.	
	death ritem iner m	Fur	11. Marital Status	. 17	Armed Fo	edent Ever in U		Was Decedent of H f Yes, specify Cuba	ispanic Origin In, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)		Race - Ameri Black, White,		
920	s after al", o Exami	d by	1 ☐ Never Marr 3 ☐ Widowed	• •	If Von Civ	/e		I □ Yes 2 🛣 No	Specify:			cify: whi		
21215-0036	hour Inatur dical I	Completed	15. Decedent's Education 16a. Dece					dent's Usual Occupation kind of work done during most of working			16b. Kind of Business Industry			
121	thin 72 ene. than he Me	mo	Elementary/Second 12		College (1		life. D	O NOT use retired)	-	-	Educa	tion/E	ood Service	
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Mar	shoull and h		19a. Informant's Na				1	-		or Rural Route Numb		,	Code)	
	and 2 Healti tem 2:		Jacque 1 20a. Method of Disp	osition		/ wife		yglass C sition (Name of	ourt;	Timonium,		093 ion - City or T	Town State	
ш О	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy figury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Donation	Cremation	3 Removal from	State	cemetery, cren	natory or other plac	i ;			•	OWII, State	
Baltimore,	permit. F Departm Importa any inju	Ì	21. Signature of Fu	-	Png/	<u> </u>		ervice Co . Name and Addres		18/2010	Towso		York Road	
8	99 <u>= 89</u>		<u> </u>	100	1 ley	<u>r</u>				ral Home,			n, MD 21204	
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3876			IF FEMALE:		22a Hunn aut									
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D.	To the Hospital or Attent within 24 hours after death To the Funeral Director: completed filled in by the		Dullaing, etc. (Specify) City or Town, State)											
	Hosp 24 ho Fune leted f	Medical	(Check 2		kaminer: On the bas	is of examination	on and/or invest	igation, in my opinic	n, death occu	ice, and due to the c irred at the time, date	and place, and	due to the ca	ause(s) and manner stated.	
	To the within 2 To the comple	≥							Psc. License number 29d. Date signed (Month, Day, Year)					
									132808			7/15/10		
	10	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anna Lange Villamian Can								Ms				
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature								y						
	Registra		SEP 2	1 2010	Ceren	J.	South	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death . Social Security Number 579 – 42 – 5351 7. Age (In yrs. last birthday) 8. Date of Birth If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** (Month, Day, ne 21 1 🔀 M 2 🗆 F Months Min. Director Usual Residence of Decedent 28a-f show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director Calvert Examiner must be notified MD St. Leonard 1 ☐ Yes 2X No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? with Funeral 5415 Mackall Rd 20685 USA items 23a filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ö þ 1 Never Married 2 Married 1 XYes 2 ☐ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. 'natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Steel Metal Worker Commercial N/A Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Anastasia Barbara Runovich Charlie Arthur Sickle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5415 Mackal Rd St Leonard, MD 20685 Robert Sickle, Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Final 9/21/10 Journey Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Charisse N. Woods . Signature of Funeral Service Licensee 2700 Edmondson Ave. Balto., MD 21223 23a. Part . Inter the disease, or complications that caused shock, or heart fatture. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ hromic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

A Pregnant at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year Yes 2 No □ Unknown 9 Unknown the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performe 2 🗌 No 1 🗌 Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မြ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury after death. Director: Af Accident 1 ☐ Yes 2 ☐ No M Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Within 2 only one) 29b. Signature and title o 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

140,

Harrita

110

31. Date filed (Month, Day, Year,

Prince Frederick

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 16 Tane.ia 2010 8:00 AMM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Burtonsville 14625 Blackburn Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F Oct. 11, 13925 Months Days Hours Min India 84 215-76-3880 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Burtonsville Montgomery 1 🗌 Yes 2 🙀 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number India 20866 14625 Blackburn Road

1 ☐ Yes 2 🔀 No Specify:

22. Name and Address of Facility

(Give kind of work done during most of working life. DO NOT use retired)

16a. Decedent's Usual Occupation

Accountant

20b. Place of Disposition (Name of

cemetery, crematory or other place)
Atlantic Crematory, Inc.

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

18. Mother's Name (First, Middle, Maiden Surname)

Sukh Devi

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14625 Blackburn Road, Burtonsville, Maryland 20866

09/18/2010

14 Bace - American Indian. Black, White, etc.

16b. Kind of Business Industry

U.S. Government

20c. Location - City or Town, State

Glen Burnie, Maryland

2010

Asian

traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Man ဂ Gobind Ram Taneia 19a. Informant's Name/Relationship (Type, Print) Sunil Taneja - Son 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Ligens shock, or heart failure List only one cause on each Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Physician/Medical Examiner if any, leading to immediate Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No g Unknown Unknown Completed by this certificate has within 24 hours after death.

To the Funeral Director; After this certifical completed filled in by the funeral director, I Be 25. Was case referred to medical examiner? Hospital: 2 No မ 1 Tes

27. Manner of Death

1 Natural

Accident

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

29b. Signatur

(Check

31. Date filed (Month, Day, Year)

5 Pending

Certificate:

Medical

For State Registrar

10a. State

Maryland

11. Marital Status

1 Never Married 2 Married

15. Decedent's Education

(Specify only highest grade completed)

3 🌠 Widowed 4 □ Divorced

Elementary/Seconday (0-12)

17. Father's Name (First, Middle, Last)

12. Was Decedent Ever in U.S.

Yes 2 No

If Yes, Give Year or Dates

College (1-4 or 5+)

Physician/

Medical

Examiner

Funeral

Director

or 28a-f shov

items 23a

0

"natural",

Director

Funeral

Completed by

Be

Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Donset and Death Due to (or as & Behue Due to (or as a consequence of) Due to (or as a consequence of) 23d. Date of delivery Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No Yes 2 1 No 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 4 Nursing Home 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

City or Town, State)

DHMH 17 Rev 7/2009

State Registrar (Item 23a) (Type, Print)

🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1JEA Medical icility Name (if not institution, give street City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs, last birthday) **Funeral** Hours **Director** 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene.
Important: If item 27 is marked of ther than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location Director 1 Tes 2 No 10g. Citizen of What Country? by Funeral . Was Decedent Ever în U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 Yes 2 If Yes, Give 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) onday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) မှ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cit 20a. Method of Disposition 206 Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) . Signature di F<u>une</u>ral Service Dicensee MO155 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Mastrointestinal Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown g Unknown signed by t 23e. Did tobacco use con eto the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by veral 1 Tes No 3 Probably 4 Unknown director, page 2 should peen 24b Were autopsy findings available prior to completion of eause of death? 24a. Was an certificate has autopsy perform 1 🗌 Yes 2 No Be 25. Was case referred to predical 26. Place of Death (Check only one) examiner? မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide work? 1 🔲 Yes 5 \square Pending 2 🗌 No Investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) deter Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death paccured at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death and place, and due to the cause(s) and manner stated. (Check only one) ho completed cause of death (Item State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death Day Year **Physician** MAFO: OI homa september 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give Examiner Bathmore Hospital ltimore City If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Pay, 1) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 X M 2 □ F Months Days Hours Min. 245-03-146 Usual Residence of Decedent 418 North Director arblina 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Injury or other traumatic event, the Medical Examinational be notified at 1 XYes 2 ☐ No Md. Director imore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: items 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DQ NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bethlehe 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Pr t) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (wife, Health em 27 i permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other 1 once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or 20a. Method of Disposition Dat 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Fature of Typeral service Lity issee

Fature of Typeral Service Lity i Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Hherosilerotic Physician ndiarasi disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off burial-transi and Due to (or as a consequence of) Box 68760. attending physician for use as the burial Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 5 ☐ Other (specify) signed by the a ☐Yes 2 ☐ No o 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Hospital o 124 hours af e Funeral Di 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 53377 17, 2010 W D

State Registrar A HA-JABIN

DHMH 17 Rev 1/2001

1 ho ve

WD 31212

30. Name an laddress of person who completed cause of death (Item 23a) (Type, Print)

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			Amend #8 per Fil G907 9724/10 TT State of Maryland / Departm	lible Ink. Ensure A	II Copies A	re Legible.	
				nent of Health and Iv cate of Death		^{ne} 2010	29573
П	.		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia Medic		Marie Anna Tarneski		Sept.	19, 201	10 1:45A M
	Examin	er	4605 - 3 31 -	City, Town, or Location of Death		4c. County of Deat Baltimo	
	Funeral	_		Baltimore Jnder 1 Year If Under 24 Hrs.	8. Date of Birth	g. Birt	hplace (State or Foreign
	Director		218-36-5049 1 M 2 🕪 90 Yrs. Mon		(Month, Day, Ye	1920 Mar	untry)
	nd how at	ž	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	1			10d. Inside City Limits
	filed within 72 hours after death with the Maryland they giene. Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Director	MD Baltimore Dundalk				1 🗆 Yes 2 🔼 No
	h the lagar 2	a Di		f. Zip Code	10g	. Citizen of What Co	untry?
	ms 2%	Funeral		21222	aif. Van av Na	U.S.A	
ဖ	er des or ite miner		1 Never Married 2 Married Armed Forces? If Yes,	Decedent of Hispanic Origin? (Spe- specify Cuban, Mexican, Puerto F	Rican, etc.)	14. Race - Ame Black, White	
Ř O	urs aft ural", al Exau	ted t	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	es 2 No Specify:		Specify: Wh	nite
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	1 and 2 should be f Health and Men item 27 is marke other traumatic			dress (Street and Number or Rura undalk Avenue			
_			20a. Method of Disposition 20b. Place of Disposition	(Name of		c. Location - City or	
<u><u>ä</u></u>	. Page 1 tment of tant: If it jury or o		4 □ Donation 5 □ Other (Specify) Chesapeake	e Crem. 9-22		eltsvill	e, MD
Ba	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee 22. Nam	^{ne and Address of Facility} CAF 7 Green Pastu	A/Steph	en Lohrn	nann PA
Ħ			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.			DAIC. 2	Approximate
we P	h, sician/		Immediate Cause (Final disease or condition Renal Cancer				Interval Between Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence of):				
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3876	rtificat ing ph e as th	/Mec	IF FEMALE:			1	
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours affect death. To the Luneral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Completed by Physician/Medica		opic pregnancy er (specify)		23d. Date of de Month	livery Day Year
P.O.	that tr ned by detac	y PF	Part II. Other significant conditions contributing to death but not resulting in the underly	ying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ds,	quires en sig ould be	ted k	Dementia		1 🗆 Yes	2 No 3 P	robably 4 Unknown
o co	law re nas be	nple			24a. Was an autopsy	prior to	topsy findings available completion of cause of
Re	icate l		SC West and the second		performe 1 Yes 2		s 2 No
ita	sician certif irecto	o Be	25. Was case referred to medical examiner? 1 \[\subseteq \text{Vas} \ 2 \subseteq \text{No} \] Hospital: 1 \[\subseteq \text{Impatient} \ 2 \subseteq \text{EB/Outpatient} \ 3 \]	26. Place of Death (Check			
ot	ig Phy terthis nerald	te: To	27. Manner of Death 28a. Date of injury 28b. Time of	28c. Injury at	me 5 N Hesidenc 28d. Describe how i	e 6 Other (Specinjury occurred	rty)
0	tendin leath. or: Aft the fur	Certificate:	2 Accident Investigation M				
Division of Vital Records,	ital or Ature after drain Direct	_	4 Homicide determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)		City or Town, S		
	e Hosp 24 hor e Fune e Fune	Medica	29a. Certifier 1	n, in my opinion, death occurred at	the time, date and p	lace, and due to the	cause(s) and manner stated.
	vithii To th	_	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Montl	7. Dav. Year)
			- Calla Cliff wo	DU051185	Se	ptember 2	0,2010
	DV		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Colven Christmas, WD 5505 Hopkins Bayvick 31. Date filed (Month, Day, Year) SEP 0 1 2010	J Crock. Baltin	ione, Man	yland 218	124
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		For State		State	of M	larylan		artmen <i>rtificate</i>		Health and	Mental Hy	•	0.0	10	20571
		Registrar 1. Decedent's Name			-			Timeatt	5 OI L	Jean	2. Date of De				3. Time of Death
Physicia Medic				ttmar Ro		Tie	tjen				Septem	ber	² 1 ⁶ , 2	ŎĨO	1:05 A M
Examin	er	4a. Facility Name (if Ingleside	at Ki	ng Farm				4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery			
Funeral Director		5. Social Security No. 060-20-11	183	6. Sex 1 ⊠ M 2 □ F		je (In yrs. Ia 8 6	Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	Jan • 20	th y, Year 1	924		place (State or Foreign try) York
and show	tor	Usual Residence of 10a. State	10b. County			10c. City	, Town or L							10	0d. Inside City Limits
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with the	Funeral Director	10e. Street and Nun 701 King		Blvd.				10f. Zip		850		-	Citizen of W .ited		-
r death r items iner m		11. Marital Status 1 □ Never Marr		12. Was De Armed	Forces?		3. 13.	Was Deced	lent of Hi ify Cuba	lispanic Origin? (Span, Mexican, Puert	pecify Yes or No- o Rican, etc.)			- America	
urs afte ural", o I Exam	ted by	3 Widowed		If Yes C	ive	WWII		1 🗌 Yes	2 🛚 No	Specify:			Specify:	Whi	ite
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I within ygiene.		Elementary/Seco	onday (0-12)	College 5+	(1-4 or	5+)				t of Sal	es		A1um	inum	
d be filed Mental Hy arked otl	To Be	17. Father's Name (I		_{last)} is Tietje	n					18. Mother's Nar Isabel	ne <i>(First, Middl</i> e le Buist		n Surname)	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na Nancy A.					19b. Mail 701 I	ing Address King F	(Street arm	and Number or Ru B1vd . 非620	ral Route Numbe	er, City (7 i11	or Town, St .e,Ma	tate, Zip C ry1a	nd 20850
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Medical Examiner		disease or conditio resulting in death)	n	a. Due t	o (or as	a opnsequ	ence of):	<u>~</u> .							
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death ce ne attend ed for us	Physician/Medic	23b. Was decedent in the past 12 r 1 Yes 2 Unknown	months?		e Birth	of pregna 2 Feta at time of c	I death 3	☐ Ectopic p☐ Other (sp		су			23d. Dat Mor	e of delive	ery Day Year
hat the ed by t detach	y Ph	Part II. Other signif		ons contributing to	death I	out not res	ulting in the	underlying (cause giv	ven in Part I.	23e. Did	tobacco	use contri	ibute to th	ne cause of death?
quires t en sign ould be	ted by										1 🗆	Yes	2 🗌 No	3 🗌 Prob	pably 4 💢 Unknown
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nding F ath. :: After	icate	27. Manner of Death 1 Natural 2 Accident	n 5 □ Pendir Investi	19	te of inju onth, Da		28b. Time of injury	of 2	8c. Injury work 1 🔲		28d. Describe	how inju	ury occurre	ed	
l or Atter after deg Director I in by th	Certificate:	3 Suicide 4 Homicide	6 Could determ	not be 28e. Pla		ury - At ho c. (Specify,	me, farm, st	reet, factory	, office		28f. Location (City or To			er or Rural	Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	edical	29a. Certifier 1 (Check 2	Medical E		asis of e	examination	and/or inve	stigation, in	my opinio	on, death occurred	at the time, date	and plac	ce, and due	to the cau	use(s) and manner stated
To the within To the compl.	Σ	only one)3 29b. Signatur and	title of cortifie	Nurse Practione	i: io the	e pest of my	knowledge,			e time, date and pl e number	ace, and due to t		Date signed	(Month, L	
140		> Y	W	1	<u> </u>)			00	057574	t		9111	8/18	
13,1		30. Name and add Ahmed He			.33	death (Item Mill	23a) (Type, Run D	rive,	Der	wood, Ma	ryland	208	355		
State Registra	_	31. Date filed (Month	h, Day, Year) SEP 2	1 2010 32.	Redistr	ar's Signat	ure .	back	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 19. Physician/ Dorothy M. Wagner 2010 1:40 A^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 1 □ M 2 🗓 F Hours Nov 21, Year 1939 70 Yrs. Mary land 214-38-5746 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Completed by Funeral Director or 28a-f 1X Yes 2 ☐ No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 3810 Foster Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 X Widowed 4 ☐ Divorced Year or Dates 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Furniture Sales Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ္ John Rychwalski Laura Pasko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important; If item 27 is any injury or other traconce. Gale Janiszewski, Daughter 3200 Lynch Road Edgemere, Maryland 21219 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/20/10 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service License Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Arachnoid Hemory hage Onset and Death Immediate Cause (Final Physician/ 6 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner weeks neurysm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): -transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accider injury work? 5 Pending after death.

Director: Aft
d in by the fur Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Year

Beck

2010

State Registrar

only one) 29b. Signature

31. Date filed (Month, Day, Year)

ss of person who completed cause of death (Item 23a) (Type, Print)

Bino

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State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

32. Registrar's Signature

Fun Dire

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760,

	Registrar	(Eisen & 8 81-1 11- 1	and)			tificate of D		2. Date of De	Reg. No.		0 Time 12 '
,	Decedent's Name	(First, Miaale, L	Jame	s Wyn	n Jr.	JAIN!		Month	Day	Year	3. Time of Death
ii -	4a Espility Name (fig	est institution of	rive etreet and n	(mbor)		4b. City, Town, or L	acation of Deat	09	13	2010 County of Deat	
r	4a. Facility Name (If n			umper)	•			П	40.0	ourny or Deal	III
	The Johns F 5. Social Security Nui		. Sex	7 Age (In)	rs. last birthday)	Baltimore (If Under 24 Hrs	8. Date of Bi	rth	9 Rin	thplace (State or Fore
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Director	10e. Street and Numb	ber				10f. Zip-Code			10g. Citize	en of What Co	untry?
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Funeral	11. Marital Status			cedent Ever in	n U.S. 13.	Was Decedent of His If Yes, specify Cuban,	panic Origin? (S	Specify Yes or No)- 14	4. Race - Ame	
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Completed	Elementary/Secon	dary (0-12)	College	(1-4 or 5+)	life.	DO NOT use retired)	-		1	nce c	realiting
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å	17. Father's Name (Fi		,					me (First, Middle	e, maiden S	ourname)	
<u> </u>	James W.						lary L.				
	19a. Informant's Nam	ne/Relationship	(Type. Print)		19b. Maili	ng Address (Street ar	nd Number or R	lural Route Numi	ber, Cify or	Town, State, 2	Zip Code)
	Tanya Ca	bean-	Viece			Rainbow	way,				
	20a. Met od of Dispo 1X Burial 2	sition			 Place of Disposers, createry, createry 	osition (Name of matory or other place))	Date	20c. Loca	ation - City or	Town, State
	4 Donation 5				Mt. C	Carmel	9/2	21/2010) Bal	.timor	e, Md
	21. Signature of Fune	eral Service Lice	ensee	Mt	Ma	2. Name and Address Arch F/H 300 Wabas	West	. Balti	imore	e, Md	21215
7	23a. Parl 1. Enter the	disease, or co		A V	124					-	
		failure Liet eak	implications that	o used the d	leath. Do not en	ter the mode of dying	, such as cardia	ac or respiratory	arrest,		Approximate
	Imprediate Cause (Fin	failure. List only	y one cause on	each line.		ter the mode of dying	, such as cardia		arrest,		Interval Between
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Registrar

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	To the within To the	Me	29b. Signature and title of certific	er /		^	29c.	License	number			29d. Date	e signed (Mont	h, Day, Year)
			> Sumo	un la	M	· <i>J</i>)	7	5	170	3			9/15	110
	A	4	30. Name and address of person	who completed cau	ise of death (Item	23a) (Type,	Print)	Qua	220	0	Wines	11.5	21220	
	Sta	te	31. Date filed (Month, Day, Year	D.963 FR	Registrar's Signa	ture	צ שרייהל	246	NINC	D	attina	INT	1,001V	
	Registr	ar	SEP 212	1010	Registrar's Signa	. Sa	Mal							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dece ent's Name (First, Middle, Last) Time of Death 2. Date of Death Physician/ vonth 245 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death
Bath More Examiner City, Town, or Location of Death Kandallstown . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral X** M 2 □ F Months Days Hours Min Country) Director or items 23a or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location by Funeral Director TIMOre 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔏 No If Yes, Give Specify: 3 Widowed 4 ☐ Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) conday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) Middle, Maiden Surname ည iams 19a. Informant's Name/Relationship (Type. Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and 976 N. Hill Road 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State etery, crematory or other place) 4 Donation 5 Other (Specify) 21. Signature of Fun Strvice Licensee and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a conseq ence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjur attending physician and for use as the burial-transi the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Month Year Pregnant at time of death 5 Other (specify) Yes 2 L To the Funeral Director: After this certificate has been signed by the state Funeral Director: After this certificate has been signed by the state Funeral Director, page 2 should be detached? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🗡 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 2 No 1 Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Tes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Dath 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗆 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Secritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the past of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) Name and leted cause of death (Item 23a) (Type, Print) r) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ SenT Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** 4b. City nnmor If Under 1 Year / If Under 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** (Month, Day, X 1 M 2 X F Months Hours Min Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Ses 2 No mor 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral e Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?.

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced Completed injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO, NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ m t. Page 1 and 2 should b tment of Health and Mer rtant: If item 27 is mark Town, State, Zip Code) 21207 19a. Informant's Name/Relationship (Type, Caughter 19b. Mailing Address (Street and Number or Rural Route Number, permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t ree 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City cemetery, crematory or other 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
JOSEPH L. RUSS
22.2.2. W. North 21. Signat Funeral Service Licens Joseph uneral 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ emot disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and use as the burial-trai been signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No page 2 should be detached for Day Month Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has performed 2 No 2 1 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital 2 No Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manney of Death Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. ROLLING 2. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar 29581 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 17. 2010 GLADYS CALISTA CODD DAVIS WRIGHT 8:55 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore County STELLA MARIS HOSPICE Timonium If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 🗆 M 2 🗓 F Yrs Maryland **Director** 99 910 215-48-0305 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location death with the Maryland 10b County 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore County Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 2525 Pot Spring Road, Shannon 309 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ρ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Residence Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked ot ဂ Dodd Mary Agnes Hogan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1406 Broadway Road, Lutherville, Maryland 21093 John W. Wright (Son) 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Dul Valley Mem Grdns : 9/22/2010 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral South Season

Martin D. Lawson TCHELL-WIEDEFELD FUNERAL HOME, INC. 00 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) to (or as a consequence of) Examiner Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 2 🗆 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes မြ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day September DENISE 6:03 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE TOWSON TOSPIC last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 TF 01/17/1963 Washington, D.C. Director 47 217-84-3604 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director Baltimore 1 XYes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21205 $1505\frac{1}{2}$ Ashland Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Examiner Black, White, etc "natural", or 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mea College (1-4 or 5+) Elementary/Seconday (0-12) Medical Medical Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ဝ Alberta Carter <u>John Thomas Williams Jr</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Central Ave., Baltimore, Maryland 21202 <u> Aneater Williams-Ali /S</u>ister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 09/24/2010 | Baltimore, Maryland 4 Donation 5 Other (Specify) Trinity Cemetery 22. Name and Address of Facility The DERRICK C. JONES FIIT, PA. Signature of Funeral Service Lice 4611 PARK Heights Ave, BALTIMORE, MARYLAND 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Breast Priysician disease or condition resulting in death) Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy page 2 perform 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) \(\) \(\) S \(\) (Hospital: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Æ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 58303 raclino 2010

Registrar
DHMH 17 Rev 7/2009

State

6201

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Bay, Year)

SEP 2 1 2010

				1 - State of Maryland	/ Department of Health and M Certificate of Death	nental Hygien Reg. N	
		Dharaisi		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	А	Physici /Medio	cal	Eula WEDD	4h. Cit. Town and against of Dooth	109 1	8/2010 1:45 CM
	1	Examir	ier	4a Facility Name (If not institution, give street and number) HUTURECARE HOMEWOOD 2700	4b. City, Town, or Location of Death	*	N/A
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. Ia	st birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9 Birtholago (State or Foreign
		Director		215-28-3505 1 M 2 F 76 Usual Residence of Decedent	Yrs.	(Month, Day, Yea May 28,	1934 N.C.
		yland		10a. State 10b. County 10c. City,	Town or Location		10d. Inside City Limits
		ith the Marylar or 28a-1 show	Director				X□Yes 2□No
		permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any folury or other traumatic event, Ine Medical Examinar must be morified at ance.	ai Dire	10e. Street and Number 1651 E. Belvedere Ave #208	3 21239	10g. (Citizen of What Country? USA
		teme :	Funerai	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	. 13. Was Decedent of Hispanic Origin? (Sp ff Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
	39	al', or l	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No ff Yes, Give 3 ☒ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 25€ No Specify:		Specify: Black
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40	1d 2	I Hygid other	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maid	en Sumame)
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	Maryland 21215-0036	nd 2 sho alth and 27 Is m r traum		Adrienne Tubman/Daughter	19b. Mailing Address (Street and Number or Rur 1919 E. 32nd St. B	alto., Mi	y or Town, State, Zip Code) D 21218
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3	Baltimore,	nit. Parantmen ortant: Injury:		4 Donation 5 Other (Specify) 21. Signature of Fjuneral Service Licensee	22. Name and Address of Facility Be		
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20				23a. Paul. Enter the disease, or complications that caused the death. shock, or head dailure. List only one cause on each line.		or respiratory arrest,	Approximate Interval Between Onset and Death
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		Examiner			The diff.		
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3	Вох	death c s atten d for us	Physician/Me	230. Was decedent pregnant 1 Live birth 2 Fetal of the past 12 months? 4 Pregnant at time of decedent pregnant 1 Live birth 2 Fetal of the past 12 Pregnant at time of decedent pregnant 1 Live birth 2 Fetal of the past 12 Pregnant 1 Live birth 2 Fetal of the past 12 Pregnant 1 Live birth 2 Fetal of the past 12 Pregnant 1 Live birth 2 Fetal of the past 12 Pregnant 1 Fetal of the past 12 Pregnant	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
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Eula	1 0	ding Phyo The After this funeral di	n: To	27. Mann f Death 28a. Date of Injury	R/Outpatient 3 DOA Callet 4 Nursing House 128b. Time of Injury 28b. Time of Work?	28d. Describe how in	
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Webb,	Ö X:	al or Atten sefter deet I Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, late)
3		To the Hospital or Attending Physician: The within 24 hours elier deeth. To the Funeral Director: After this cartificate h completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my know 2 Medical Exeminer: On the basis of examinati and manner stated.			
_		vithin to the To the Comple	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Dey, Year)
) Ssrato	D17537		9-18-10
	n			30. Name and address of person who completed cause of death (Item DANSHINSSS) 68	-1 heisterstorm 19	Balto	21215
		Sta Regist		31. Date filed (Month, Day, Year) SEP 2 1 2010 Across A.	ball		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARY MARGARET WIHERLE -130 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS ELDERCARE LOCH RAVEN PARKVILLE BALTIMORE Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Min. 1 □ M 2 🔀 F Hours 9/19/19/29 PENNSYLVANIA 89 Director 045-18-5595 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Yes 2 XNo BALTIMORE MD PARKVILLE 23a or 2 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8121 CLYDE BANK ROAD 21234 USA items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 14. Race - American Indian, Black, White, etc 0 1 Never Married 2 Married Completed by 1 Yes : 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural" 3 ₩ Widowed 4 Divorced WHITE Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 12TH GRADE Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) DAMIAN KULICK ELLA UNAVAILABLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHELE TALTYS/DAUGHTER 8121 CLYDE BANK RD. BALTIMORE. MD 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State SACRED HEART OF injury or (1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State JESU\$ 9/22/2010 DUNDALK, MD 4 Donation 5 Other (Specify) CEMETERY Signature of Funeral Service Licensee MOO217 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final 1 MUMIC Ph sician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exami that the death certificate be executed the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown P.O. | signed to Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☑ No 24 hours after death.

2 Huneral Director; After this certific leted filled in by the funeral director, Division of Vital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2**X** No Other: မ 4

✓ Nursing Home 5

Residence 6

Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 Tes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor

To the Fune

completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆

State

DHMH 17 Rev 7/2009

the

Registrar

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 29585 State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JAMES J. YANCHESKI SEPTEMBER 12:55 A.M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death BALTIMORE GILCHRIST CENTER TOWSON Birthplace (State or Foreign Country)

MARYLAND If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Funeral Min 1 X M 2 □ F Months Hours (Month, Day, Year) 4/12/1946 Director 218-44-2122 64 Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 X No MD BALTIMORE COCKEYSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral **Examiner** must 309 LORD BYRON LANE 21030 APT. T2 USA items death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. , or i þ 1 X Never Married 2 Married 1 ☐ Yes 2 🕅 No If Yes, Give within 72 hours after 21215-0036 1 ☐ Yes 2 🔽 No Specify. 3 Widowed 4 Divorced WHITE "natural", Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the INSPECTOR AMTOTE 6TH GRADE Be Baltimore, Maryland filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental I item 27 is marked JOHN J. YANCHESKI AGNES BUZA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PEARL A. BOUSE/SISTER !\$@!! QUAIL CREEK WAY UNIT 307 SPARKS, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 9/17/2010 CATONSVILLE, MD 21. Signature of Funeral Service Lensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. MQ1139 Tal 8521 LOCH RAVEN BLVD. 21286 TOWSON, MD Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Sep813 Medical resulting in death) Due to (or as a consequence of) Examiner icat months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical that the death certificate be use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: မ ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, SEP 2 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

1)00 70635

Charles St. Svite 4105 Bultimore, MD 21204

,2010

State of Maryland / Department of Health and Mental Hygienè 1 - State Amend16a. PerWifePGC9-9-10cr Registra/Amend19b. PerWifePGC9-9-10cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ September Richard A. Astrayka 2010 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Prince George's Doctors Community Hospital Lanham 9. Birthplace (State or Foreign Country) New York If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Min. Days 1 🖾 M 2 🗆 F Months Hours (Month, Day, Year) 1/14/1933 Yrs. Director 144-26-3681 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at with the Maryland Director 1 🛛 Yes 2 🗌 No Prince George's New Carrollton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 7702 Topton Street 20784 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 🖾 Yes 2 🗌 No RICHARD Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced n | 16a. Decedent's Usual Occupation | Give kind of work done during most of working | life. DO NOT use retired | Computer Operator Year or Dates. Korean 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Government permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event* and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Alex Astrayka Antoinette Oshins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20784 19a. Informant's Name/Relationship (Type, Print) 7702 Topton Street, New Carrollton, MD 20789 Anita Astrayka / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Metropolitan Crematory Alexandria, Virginia 9/4/10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, PA Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cerebrovas cular Immediate Cause (Final Prysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ned by the atter detached for u in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 1 Yes 2 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Nes 2 No 3 Probably 4 Unknown Completed peen: 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe 2 No this certificate or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Anpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director; After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No death. 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital of 24 hours a within 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Muchan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Buand 7305 Bult mon BWd 102 31. Date filed (Month, Day, Year 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AIMOTIST 3^{Day} 20 YO 4:50 P M **ASARE** GEORGINA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S CHEVERLY PRINCE GEORGE'S HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. APRIL 18 GHANA 36 1974 Director NONE Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b, County 10d. Inside City Limits 10c. City. Town or Location Director MD PRINCE GEORGE'S UPPER MARLBORO Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 11501 HOMESTEAD DRIVE 20774 GHANA death 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 BLACK 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) 12TH HAIR DRESSER PRIVATE permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other if any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 KWAKU FORKUO FOFIE AFTA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11501 HOMESTEAD DRIVE UPPER MARLBORO, MARYLAND 20774 THOMAS APASERA/BROTHER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place RESURRECTION CEMETERY 9/24/2010 CLINTON, MARYLAND 21. Signature of Funeral Service Licenses J. B. JENKINS FUNERAL HOME LANDOVER ROAD LANDOVER MARYLAND Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line 23a, Part 1, Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition resulting in death) Medical Due to (or as a d Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death 5 Other (specify) signed by the at d be detached fr 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔏 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy page 2 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 👿 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) . Manner of Dea 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural Accident injury 5 Pendina Investigation 24 hours after death Funeral Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month. Day, Year)

State Registrar who completed cause of death (Item 23a) (Type/Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 09 Month Day Physician/ WILLIE ARNETT 2010 10:40 P M 04 Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST TAKOMA PARK MONTGOMERY COUNTY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 Hours MAY 26, 1917 GEORGT A 220-34-8247 Director 93 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 □ No MD PRINCE GEORGES BOWIE 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 12200 WYNMORE LANE 20715 USA items death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 A No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. or \$ 1 Never Married 2 Married Yes Yes, Give within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK "natural" 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12TH College (1-4 or 5+) FILE CLERK FEDERAL GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM ROBERT COLLINS NANNIE DOWLING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAULINE ARNETT/DAUGHTER 12200 WYNMORE LANE BOWIE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Deremation 3 Removal from State METROPOLITAN CREMATORY9/07/2010 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARSHALL'S FUNERAL HOME Signature of Funeral Service License 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final -Physicianπ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and I-transit Exami us piraton Due to (or as a consequence of resulting in death) Last attending physician a for use as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 1 Tes 2 No 3 Probably 4 Unknown been signature Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed' certificate 1 🗌 Yes 2 🗆 No Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ဂ္ 1 Npatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funeral filled in by the funeral completed filled in by the funeral completed filled in by the funeral (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

State Registrar 31. Date filed (Month, Day, Ye

2010

Hoventist Hospital

MD

address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

10-06509	
David Ardis	

avid Ardis		1- For State	epartment טיי דּוּנ Certificate			vientai ny		2010	29589
Physicia	ın/	Registrar 1. Decedent's Name (First, Middle,Last)					2. Date of Deal	eg. No. th Day Year	3. Time of Death
ledical Examir	ner	David Wayne Ardis					August 28	, 2010	2028 hrs
ď		4a. Facility Name (if not institution, give street and number Peninsula Regional Medical Center	r)		, Town, or Loc sbury	cation of Death		4c. County of De Wicomico	ath
Funeral Director		5. Social Security Number 09 6. Sex 7. A 216 66 9809	ge (In yrs. last birthday 48) If Ur Mon Yrs.		If Under 24Hrs. Hours Min.		th(MM/DD/YYYY) 9. For 1962	Birthplace (State or eign Country) MD
Å		Usual Residence of Decedent	10c. City. Town or Lo						10d. Inside City Limits
ow any		10a. State 10b. County MD Worcester	Snow I						1 Yes 2 X No
daryland 28a-f show 1 at once.	Director	10e. Street and Number	3HOW I		ip Code		1	0g. Citizen of What C	ountry?
the Ma 3a or 23		5997 Snow Hill Road			21863	3		USA	
death with or items 2.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Force:				nic Origin? (Sp exican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race - Am White, etc	nerican Indian, Black,
s after ral",	ã	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	_	2 X No s		ia. a	Specify:	white
21215-0036 Juld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once	Completed	15. Decedent's Education (Specify only highest grade of Elementary/Secondary (0-12) College (1-4 o 4	r 5+) durin	g most of w	orking life. DC	(Give kind of wood NOT use retired in a reverse Ret		16b. Kind of Busines Poultry	ss/industry
15-003 Hed withi Hygiene. If other th	E S	17. Father's Name (First, Middle, Last)	3210					Maiden Surname)	
21215-0036 uld be filed within 7. Mental Hygiene, marked other than	Be	Albert N. Ardis					n McRob		
Baltimore, MD 212 permit. Pages I and 2 should by Department of Health and Ment Important: If item 27 is mark injury or other traumatic even	ို	19a. Informant's Name/Relationship (Type, Print) Kathleen M. Ardis (Mot			ss (Streetan ow Hill			nber, City or Town, St H ill, M D	ate, Zip Code) 21863
e, M and 2 Health item 2		20a. Method of Disposition	20b, Place of Dis	position (N	ame of cemete		Date	20c. Location - City	
nor Pages 1 mt of H nt: If		1 X Burial 2 Cremation 3 Removal from S	State crematory of Whatcoat		-	09-0	1-2010	Snow Hil	1, Maryland
altir mit. P partme portai		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee				Facility L Home	2010	bhow hill	i, maryrand
		Adjuilly		13 Eas	st Grov	e Stre		lmar, DE	19940
Physician /Medical Examiner		ininediate Gause (Final disease a	injuries	er the mode	e of dying, suc	ch as cardiac or	respiratory arr	est, snock, or neart	Approximate Interval Between Onset and Death
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ecuted and transit	al Examiner	(Disease or in jury that initiated events resulting in death) Last Due to (or as a cond.)	sequence of):						
6 be exe ysician (edical	▼ UNPENDED	,28a-f ,per	ME g	908 10	.4.10 T	T	1	
	-≥	23b. Was decedent pregnant in the past 12 months?	ome of pregnancy at time of death 5	Fetal deat		Ectopic pregna	ncy	23d. Date of deliver Month	very Day Year
. Bo	hys	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to dea	ath but not resulting in the	ha undaelui	na navana aiva	n in Port I	23e Did to	phacco use contribute	to the cause of death?
ires that the signed by	Š	Tarkii. Other significant conditions - contributing to dea	att but not resulting in t	ne underly	ng cause give				robably 4 V Unknown
of Vital Records, ag Physician: The law requir Wher this certificate has been some all director, page 2 should	Completed						24a. Was autop		autopsy findings available to completion of cause of
Recc The lav	mo				-		1 Yes	rmed? death 2 No 1 ✔	
tal Recian: The	Be	25. Was case referred to medical examiner?			LOth	Death (Check o			-
Physical this	ို	1 Yes 2 No	ient 2 🗸 ER/Outpati		DOA 28c. Injury a			Residence 6 Of	her:
_ = ^ 2	ţi	1 Natural 5 Pending (Month, Day			1	2 No		driver o	f vehicle r vehicle
Division of Vital Fro the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,	ertification:	3 Suicide 6 Could not be 28e. Place of	Injury - At home, farm, s	-	ry, office build	ding, etc.	28f, Location (S	Street and Number or State), Nassawa	Rural Rou e Nim er, Cry ngo & now H111, MI
Hospital 14 hours Funeral	ပ	29a. Certifier 1 Certifying Physician: To the best of	roadway my knowledge, death o	ccurred at t	he time, date a	and place, and	due to the caus	se(s) and manner as s	stated.
To the Howithin 24 h	Medical	one) 2 Medical Examiner: On the basis of examiner state	amination and/or invest				t the time, date		
	Σ	29b. Signature and title of certifier		2	9c. License nu O.C.M.E	0.0	OME	29d. Date signed (August 29, 20	
		30/Name and address of person who completed cause of	death (Item 23a)	N.					
			Medical Examiner	111 F	enn Stree	et, Baltimore	e, MD 21201	1	
Sta Regist	ate rar	31. Date filed (Month, Pay, Near) 2010 32. Regist	rar's Signatur	a Har					

10-07017

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Tina Marie Ayres State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3 Time of Death Physician/ Month Day Year September 12, 2010 Medical Examiner 1040 hrs TIMA MARIE 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 214 Southerly Road Brooklyn Anne Arundel 5. Social Security Number 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Hours Director 217.82.4395 Country) MD 1 M 2 F any 10d Inside City Limits 10c. City. Town or Location s 23a or 28a-f show a 1 Yes 2 No imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygene.
and I fitem 27 is anxied other than "natural", or items 23a or 28a-f sho or other trannatie event, the Medical Ex miner must be notified at once. Director 10e Street and Number 10g, Citizen of What Country? 4400 SANTERD Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes If Yes, Give Year or Dates: 3 Widowed Specify: 4 Divorced 1 Yes 2 No specify: ρ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade comoleted) 16b. Kind of Business/! Completed Elementary/Secondary (0-12) College (1-4 or 5+) ITNDER 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number UDE SCOTLAND RD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 Cremation 3 Removal from State Donation 5 Other Specify: vice. INTAIN RO MEADENA, MD. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and **Physician** /Medical a. Complications of Chronic Alcoholism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last certificate be executed attending physician and for use as the burial - transi Physician/Medical UNPENDED AMENDED Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify, After this certificate has been signed by the att funeral director, page 2 should be detached for 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death, 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Other₄ Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 Other: Scene 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No 5 Pending Fo the Funeral Director; completely filled in by the Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 13, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registra s Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 23a per med cert G907 9/30/10 dk

State of Maryland / Department of Health and Mental Hygiene () | () 29591 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 6. 2010 0407 Ada Emma Barnes 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Havre de Grace

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Harford Harford Memorial Hospital Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Months 1□M 2√F Yrs. 1928 82 Aug. Pennsylvania 201-22-3199 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 X Yes 2 No Perryville Maryland Cecil 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21903 U.S.A. 625 Broad Street Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Perry Point Nursery School Perry Point, Maryland Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Four Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Annie Laurie Gee Rush Paul Kidder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 625 Broad Street, Perryville, Maryland 21903 19a. Informant's Name/Relationship (Type, Print) Linnie L. Barnes (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State West Chester, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A.Ferris & Co., Incl. 09/07/10 Pennsylvania 21. Signature of Funeral Service Licensee Lee And Patterson & Son Funeral Home Perryville, Maryland 21903-0766

permit. Pages 1 and 2 s Depertment of Health ar Important: if teem 27 le eny Injury or other treu once. **Physician** /Medical Examiner

attending physicien and for use as the burial-transit

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by Physician/Medical

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P.O. Box 68760.

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Maryland 21215-0036

Baltimore,

Examiner must be notified at

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Completed

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine

Immediate Cause (Final disease or condition resulting in death)

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SHOCK CARDIOGENIC Due to (or as a consequence of): Acute Myocardial Infarction Due to (or as a consequence of)

Atrial Fibrillation

Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Winknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy perform 2 **N**o 1 Tes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

Approximate Interval Between Onset and Death

Year

26. Place of Death |Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

2 Accident

3 Suicide

5 Pending investigation 6 Could not be determined

1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Hospital:

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Dey, Year)

D 0069 118

9-6-10

30. Name and address of person who completed cause of death (hem 23a) (Type, Print)

KHALID PUTHAWALA 31. Date filed (Month, Day, Year) SEP 0 8 201

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Margaret Burgoyne 2010 9:37 Ам September Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Prince George's Hyattsville 5006 56th Avenue 8. Date of Birth (Month, Day, June 3, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Hours England 134-12-8826 91 Ĩ919 <u>June</u> Director Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director Maryland Prince George's Hyattsville 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **IISA** 20781 5006 56th Avenue within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status er than "natural", or iter the Medical Examiner Armed Forces Black, White, etc 1 Never Married 2 X Married Yes 2 🛛 No δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. White If Yes. Give Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 treent of Health and Mental Hygiene. tant; If item 27 is marked other than jury or other traumatic event, the M6 Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Violet Robinson Alfred Jowett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5006 56th Avenue, Hyattsville, MD 20781 Herbert W. Burgoyne / Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 Burial 2 X Cremation 3 Removal from State Alexandria, Virginia 9/7/2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac Arrhythmia Medical resulting in death) Due to (or as a consequence of). Examiner Alzheimer's Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury Osteoarthritis and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🖾 No Month Day Year signed by the a ld be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s has autopsy performed? 1 Yes 2 No Yes 2 X No certificate 25. Was case referred to medical Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify Hospital: 2 X No 1 Inpatient 2 I ER/Outpatient 3 I DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 X Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide determined Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the Within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier VICKEN D34722 9/7/2010 PODCATKIAN, MP Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month, Day, Year)

SEP 0 8 2010

32: Registrar's Signatur

K. Poochikian, 5632 Annapolis Road, Suite #3, Bladensburg, MD 20710

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) ADr. 16,1932 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) **Funeral** California 1 - M 2 XF 559-42-0722 78 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at Maryland | Montgomery 1 ☐ Yes 2√ No Burtonsville Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 3633 Turbridge Drive 20866 United States Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Charles Pusich Margaret J. Derenia ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bevan H. Brown -husband 3633 Turbridge Drive Burtonsville, Maryland 20866 20a. Method of Disposition
1 ☐ Burial 24 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metropolitan Crematory 9/3/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald Wide Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one d Immediate Cause (Final disease or condition resulting in death) **Physician** MycCardia /Medical Due to (or as a consequence f) **Examiner** otic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and I for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 000 this certificate e Hospital or Attending Physician: 124 hours after death. e Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 4 \sum Nursing Home 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 🗌 DOA 5 🗌 Residence 6 Other (Specify) မ 28a. Date of Injury (Month, Day Year) completely filled in by the funeral Manner of Death Time of 28c 28d. Describe how injury occurred Injury at Work? Certification: 5 Pending investigation Natural 2 Accident Injury 1 | Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 29a. Certifier (check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29b. Signature and title of certifier

CR_ 15

State 31. Da Registrar

31. Date filed (Month, Day, Year)
SEP 0 8 2010

32. Registrar's Sign ture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

Res-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29594 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 2010 A^{M} 2:12 September Mc Allister Adelaide Bristow Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year Jan 31, 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛛 F Months Davs Hours Min. North Carolina Director 89 246-24-0707 Jan. Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Maryland Prince George's Capitol Heights Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? must be r ō Funeral 20743 United States 7427 Calder Drive items within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc. African n "natural", or iten ledical Examiner n 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 Specify: American 1 Yes 2XXNo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) e 1 and 2 should be filled within 72 h t of Health and Mental Hygiene. If iten 27 is marked other than "n or other traumatic event, the Medi Elementary/Seconday (0-12) College (1-4 or 5+) Government vears Substitute Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Margaret Hill William Greene Mc Allister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10249 Prince Place #T3 Upper Marlboro, MD 20743 Delia Bristow - Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sept. 11, 2010 Fayetteville, NC Northside Cemetery 22. Name and Address of Facility Stewart Funeral Home, Inc. nature of Funeral Ser 4001 Benning Road, NE Washington, DC 20019 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to leas a consequence of: Examiner nuemma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner a surissuluries of or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached f g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 10 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) e Hospne... n 24 hours after death. he Funeral Director: After th funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

completed filled in by within 2 To the F

Hospital

State Registrar

Medical

29a. Certifier

29b. Signature and title of certified

30. Name and address of person who completed cause of death (Item 23a), (Type, Print)

M. A.M. B. V. C.E. (B. G. HUS), (T. HUS AW 32. Registrars Signat

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c, License number 000 43662

City or Town, State)

3001 Hosp Dr Cheverly Md

29d, Date signed (Month, Day, Year)

		-	For State of State of Registrar	Maryland /		rtment of H tificate of D			ene g. No.2010	29595	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	-				2. Date of Death	1	3. Time of Death	
	Medic	al	Lawrence Joseph Beavers 4a. Facility Name (if not institution, give street and numb	ar)		4b. City, Town, or	Location of Death	Septembe	er 4, 201		
	Examin	er	14 First Street	o.i,		Indian			Charles		
	Funeral		5. Social Security Number 6. Sex 7	. Age (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day, May 12,	9. E	Birthplace (State or Foreign Country) Maryland	
	Director		Usual Residence of Decedent	74	110.			May 12;	1936 1	waryiand	
	ryland I-f sho ied at	ctor	10a. State 10b. County Maryland Charles	10c. City, To	wn or Loc ian F					10d. Inside City Limits 1 🌠 Yes 2 □ No	
	he Ma or 28a s notif	Dire	Maryland Charles 10e. Street and Number	IIIQ	Tall I	10f. Zip Code		11	0g. Citizen of What		
	s 23a uust be	Funeral Director	14 First Street			2064	0		U.S.A.		
	r death r item iner m		11. Marital Status 12. Was Decedor Armed Force 1 Never Married 2 Married 7 Yes 2	es?	lf lf	as Decedent of His Yes, specify Cuban	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wh	nerican Indian, nite, etc.	
920	rs afte iral", c Exam	ed by	1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes, Give Year or Date	1954 195	- 1 8	☐ Yes 2 🔀 No	Specify:		Specify: [W]	nite	
15-0	72 hou "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)		6a. Deced (Give k	ent's Usual Occupa ind of work done du	tion uring most of worki	ing	16b. Kind of Busines	ss Industry	
212	sfiled within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		Elementary/Seconday (0-12) College (1-4			NOT use retired) sive Ope:	rator		U.S. Gove	ernment	
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)	-	·		18. Mother's Name		laiden Surname)		
	ould be id Men marke matic		Shick Rollins 19a. Informant's Name/Relationship (Type, Print)	1	Oh Mailin	n Address (Street a		Beavers	City or Town, State,	Zin Code)	
Σ Σ	in and 2 should be file of Health and Mental Fitem 27 is marked or rother traumatic even					rst St.,			-		
ore	ye 1 an t of He Hriten or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from S	tate ceme	etery, crem	sition (Name of atory or other place	⁹ Sept. 1(2010	20c. Location - City		
<u>H</u>	permit. Page 1 Department of Important: If it any injury or o once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lio	Mary	land	Veterans	Cemetery	7		am, Maryland	
Ba	Dep lmp	y 1	White	M0066	8 Wi	Name and Address 111ams Fi 270 Hawtho	uneral Ho orne Rd.	ome, P.A. . Indian	Head, Md	20640	
			23a. Part 1. Enter the disease, or complications that co shock, or heart failure. List only one cause on each	used the death. Do	o not ente	r the mode of dying	, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death	
	Priysician/ Medical		Immediate Cause (Final disease or condition resulting in death)		e off:	7 65	50/01	Duce	L'10TE	Offset and Death	
	Examiner		Sequentially list conditions, b.	as a sonocquene							
-	sit sit	Examiner	Cause (Disease or linjury	as a consequenc	e off.						
	executed an and rial-transi	Exal	that initiated events c	as a consequenc	ce of):						
09	icate be executed physician and s the burial-transit	edical	d								
/89	certifica Iding p	/Me		ome of pregnancy					23d. Date of	delivery	
Box	requires that the death certificate be been signed by the attending physicic should be detached for use as the but	Physician/M	in the past 12 months?	rth 2 Fetal de int at time of deatl		Ectopic pregnancy Other (specify)			Month	Day Year	
P.O.	at the c d by th etache	Phys	g Unknown Part II. Other significant conditions contributing to dea		na in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?	
S, P	ires th	d by								Probably 4 Dunknown	
örd	≥ 00	Completed						24a. Was an		autopsy findings available to completion of cause of	
Rec	The ate pag	Com						perform	ned? death		
/ita	sician; certifi	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	patient 2 🗆 ER/	(Outpotion	Othe	r:	•	C C Other (Co	- e if s)	
ot V	ng Phy ter this neral d	te: To	27. Manner of Dea 28a. Date of		o. Time of injury	28c. Injury	at	28d. Describe how	nce 6 Other (Sp w injury occurred	есіту)	
ion	ttendir death. ttor: Af	Certificate:	2 ☐ Acident Investigation 3 ☐ Suicide 6 ☐ Could not be	f Injury - At home,	form etro	M 1□`	Yes 2 □ No	20f Legation (Ctr	enet and Number or	Rural Route Number,	
Division of Vital Records,	al or A s after il Direct			, etc. (Specify)	, ram, sire	ot, ladioly, office		City or Town,		iura noute number,	
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis	of examination and	d/or investi	igation, in my opinior	n, death occurred at	t the time, date and	d place, and due to the	e cause(s) and manner stated.	
	Fo the within 2 Fo the Somple	Ě	only one) 3 Certifying Nurse Practioner: To 29b. Signature and title of certifier	the best of my kno	owledge, d	eath occurred at the 29c. License			cause(s) and manner 9d. Date signed (Mo		
			1 K Moule			07	835)	97	10	
R	B. Fall		30. Name and address of person who completed cause	of death (Item 23a	a) (Type, P	rint)	PICIO	- W	50 20	1641	
V	Stat		31. Date filed (Month, Day, Year)	gistrar's Signature		4.0	C- 0			-076	
	Registra		NEW HY WHILE I // No.	and a Pl.	120.00	A COLOR					

			For State Registrar	State of M	aryland / l		artment <i>tificate</i>			and Mei		giene	010	295	96
	874 E		Decedent's Name (First, Middle)	, Last)		-				2.	Date of Dea	ath Day	Year	3. Time of	
	Physicia /Medic		Dorothy	J. Z	Bowers	ì				5	ept.	13	2010		5AM
	Examin		4a. Facility Name (If not institution	, give street and number)			4b. City, T		/				County of Deat	1	
		€.	Golden Living	Center	/I I I	ال مام مام ما	if Under		If Under		Date of Birt		Washin	place (State o	r Foreign
12	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last bi 76	Yrs.	Months	Days	Hours	Min.	(Month, Day	y, Year)	934 Pen	untry)	
H	Director		204-26-9330 Usual Residence of Decedent		70						arcii	J, 1.	754 1 611		
	yland how at		10a. State 10b. County		10c. City, Tov									10d. Inside Ci	
	e Ma Ba-f s	cto	PA Frank	lin	Mer	cer	sburg					10a Citi-	zen of What Co		
	with the	D E	10e. Street and Number 13179 Lindo	+ Pood			10f. Zip	172	36		:	rog. Citiz	US		
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther, the Medical Examiner must be notified at	Funeral Director	131/9 LINGO	12. Was Decedent	Ever in U.S.	13.	Was Deced			igin? (Specif	y Yes or No can, etc.)		14. Race - Ame		
(0	r iten r iten niner	표	1 □ Never Married 2 🌠 Marr	Armed Forces'			If Yes, speci 1 □ Yes 2				can, etc.)		Black, White		
036	ral", o	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:									Specify: Wh		
5-0	72 h "natu	etec	15. Deceden (Specify only highe	t's Education st grade completed)	168	a. Dece (Give	dent's Usua kind of wor	l Occupa k done c	ation during mos	st of working		16b. Kii	nd of Business/	Industry	
21215-0036	within ene. than he Me	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		Homem					0	wn home		
d 2	i filed I Hygi other ent, t	BeC	17. Father's Name (First, Middle,	Last)					18. Moth		First, Middle,				
<u>lan</u>	uld be Aenta rked tic ev	10 B	Clarence Lowa	ins							7 K. A				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations								Route Numb Cersbu		r Town, State, 2 PA 172		
	1 and 2 Health a tem 27 is		Harold E. Boy	ers/husband						, Mer c			ecation - City or		
Baltimore,	iges 1 nt of H if ite or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		20b. Place cemet					Sept.	16,		cersbur		
Ξ	permit. Pages 1 Department of H Important: If ite any injury or ot		4 □ Donation 5 □ Other (S		Welsh	Rur	 Ceme Name and 	tery d Addres	ss of Facil	2010			s Funer		Ω
Ba	permi Depar Impor any ir		1/1/2 /5-	an i s			7 N.	Parl	k Ave	., Mei	rcersb	urg,	PA 17	236	
	4. 1		23a. Part1. Enter the disease, o shock, or heart failure. List	complications that cause	ed the death. Do									Approxima Interval Be	tween
	Physician		immediate Cause (Final disease or condition	(10 //	naul	- 1	arter	w	de	100	1			Onset and	Death •
	/Medical		resulting in death)	Due to (or a	s a conseque	of):		1	, .	,				4	
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	sit ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Chie to (unit	8 3 CURSH; WHITE	a vij									
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760,	eath certificate be executed attending physician and for use as the burial-transit	calE		d											
89	tificat ng phy as th			1	-								-	1	
Box	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. if yes, outcom 1 ☐ Live birth	e pf pregnancy 2 □ Fetal dea		□Ectopic pr		y			1	23d. Date of de Month	livery Day	Year
	ie dea the at ned fo	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant 9□Unknown	at time of death	5	Other (sp	ecify)						,	
P.0	w requires that the death certifica been signed by the attending ph should be detached for use as th	Completed by Physician/Med	Part II. Other significant condit	ons contributing to death	but not resulting	in the	underlying c	ause giv	en in Part	l.	23e. Did	tobacco	use contribute 1	o the cause of	death?
ds,	uires signe Id be	d by									1 🗆	Yes 2	□ No 3 □ F	robabiy 4 🗖	Unknown
Records,		lete									24a. Was		24b. Were a	utopsy findings	available
Re	The law ate has b page 2 sl	dwo							, "		perf	opsy formed? 2/X/No	death?		cause or
Vital	(0 14	BeC	25. Was case referred to medical	d					26. Plac	ce of Death	Check onl				
r V	d is	To B	examiner? 1 ☐ Yes 2 ☐ ✔ Io	Hospital: 1 ☐ Inpa			ent 3 DC		412				6 □Other (Sp	ecify)	
0 0	ffer ne	ii.	27. Manner of Death ↓□Natural 5 □ Pendi	19	njury 28b Day Year)	. Time Injury		28c. Inju Wo			3d. Describe	how inju	iry occurred		
Sio	Attending r death. ector: After by the funer	cati	3 Suicide 6 Could	gation not be 28e Place of i	njury - At home,	farm. s	M treet, factor		Yes 2		3f. Location	(Street a	nd Number or I	Rural Route Nu	mber,
Division or	after of Direct In by	Certification:	4 ☐ Homicide determ		etc. (Specify)	iaiii, o		,,			City or To	own, State	e)		
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Al completely filled in by the fu		29a. Certifier Certify	ng Physician: To the best Examiner: On the basis	st of my knowled	lge, dea	ath occurred	at the ti	ime, date	and place, a	nd due to the	e cause(s	s) and manner a	as stated.	(e)
	n 24 h	Medical	(Check only 2 Medica one)	and manner	stated.	and/or					d at the time				
	Vithi To t	Ž	29b. Signature and title of certifi		1			1	se number				ate signed (Moi		
			Manje	n y orde	V -			V	18 5	00)			9-13-	υ	
			30. Name and address of erson	who mpleted cause o	Meath (Item 23a	a) (Type	e, Print)	Hur	11-	Hade	water-		70)	1740	
	St	ate	31. Date filed (Month, Day, Yea	32. Regi	leath (Item 23a 368 Sar's Signature	1	The same	N		-	- OI UN	· ·	100	, , -, 0	
	Regist		SEP	21 2010	know	p.	7								

DHMH 17 Rev 1/2001

		-	State of Maryland / State	epartment of by 21/2010dh Certificate of L	lealth and Neath	Mental Hyg F	giene 0 1 0	29597
			1. Decedent's Name (First, Middle, Last)			2. Date of Dear	th	3. Time of Death
	Physicia Medic		Barney Boyd Bullington			Hept	Day 2 Year	0 220AM
	Examin	er	4a. Facility Name (if not institution, give street and number) Washington County Hospital	Hagerst			4c. County of Dear Washing to	n County
	Funeral Director		220 01 0170	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) Feb. 3	9. Bir 1911 Vir	thplace (State or Foreign untry) g inia
	land f show d at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town					10d. Inside City Limits
	Mary 28a-1 otifie	irec	,	amsport				1 ☐ Yes 2X No
	with the s 23a or ust be r	Funeral Director	10e. Street and Number 16505 Virginia Ave. Apt. B314	10f. Zip Code 21795	j		10g. Citizen of What Co	ountry?
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates.	13. Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 🗓 No	n, Mexican, Puerto		14. Race - Ame Black, Whit Specify: Wh	e, etc.
Baltimore, Maryland 21215-0036	thin 72 hour sne. than "natu he Medical	Completed by	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired)	ation luring most of work	ding	16b. Kind of Business Oil Compa	
9	led wil Hygie other ent, th	Be (17. Father's Name (First, Middle, Last)	anager	18. Mother's Nam	ne (First, Middle, I		LIY
/lan	d be fi //ental arked rtic ev	욘	Ira F. Bullington		Josie D	avis Bul	lington	
Mary	12 shoul		I .	o. Mailing Address <i>(Street a</i> 3331 Fairfax				p Code)
re,	1 and of Hea fitem		20a. Method of Disposition 20b. Place o	f Disposition (Name of ry, crematory or other plac		Date	20c. Location - City or	Town, State
<u>ii</u>	Page	١,		Hill Mem. Par	rk 9-13		Lynchburg,	
Ball	permit Depart Impor any in		21. Signature of Funeral Service Licensee	22. Name and Addres			Fiery Fundagerstown,	
ج ب	Hysician Medical Examiner	ner	23a. Part 1. Enter the disease, or complications that caused the death Domeshock, or heart/allure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	57 R.W. F.	PAILUR	- 4	D DME	Approximate Interval Between Onset and Death
0	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	Cause (Disease or linjury that initiated events resulting in death) Last C. Due to (or as a consequence of the consequence of	of):	000	A Rehi		
3760	ficate g phy: as the	Jedi	_ v					
Division of Vital Records, P.O. Box 687	e death certii the attending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3	ру		23d. Date of de Month	elivery Day Year
P.O.	s that th igned by be detac		Part II. Other significant conditions contributing to death but not resulting ACVIE WESCHOLAE (~FARE)				obacco use contribute t	o the cause of death?
spuc	require been s should	Completed by	DISCASE ARTERIO SCLEROTICE DISCASE AVENIA ACUTE	ARDIOVASCU	LAR	24a. Was a	an 24b. Were a	utopsy findings available
3ec	he law ite has	dwo	BACTERRALA LIPERTENSION			autop perfo 1 ☐ Yes	rmed? death?	completion of cause of
<u>a</u>	cian: T ertifica ector, p	Be	25. Was case referred to medical examiner? Hospital:		ace of Death (Chec			
<u> </u>	Physic this o	မ	1 Yes 2 No 1 Inpatient 2 ER/O	utpatient 3 DOA Other	4 LI Nursing H		dence 6 Other (Spe	cify)
o uc	nding ath. : After e funer	icate	1 Natural 5 Pending (Month, Day, Year)	injury work	Yes 2. XTNo	Fell af	ter standi	ng up
)ivisic	al or Atter safter des Director d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify) HOSp1			28f. Location (S City or Tow Hagerst	Street and Number or R rn, State) 251 E	ural Route Number, • Antietam St
_	e Hospita 24 hours e Funera leted fille	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, only one) 3 Certifying Nurse Practioner: To the best of my know	or investigation, in my opinio	on, death occurred a	ind due to the car at the time, date a	use(s) and manner as s nd place, and due to the	cause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	29c. License	e number		29d. Date signed (Mon	th, Day, Year)
			- nut mo		9019		SENT 2	, <010
_	10			MILLST	NACE	RITOL	~ ~o	21740
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	barles				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 25a per med cert G908 10/2//10 dk
State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER Day 7, 2010 Physician/ 4:30A M JEANNETTE ISABEL JONES COMPTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** QUEEN ANNE'S CENTREVILLE CORSICA HILLS NURSING HOME If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 6. Sex Funeral 1 🗆 M 2 🗶 F MARCH 31, 1925 85 Months Days MARYLAND Director 218-40-4539 Usual Residence of Deceden 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 **X** No 28a-f MARYLAND QUEEN ANNE'S CENTREVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number P items 23a Funeral UNITED STATES 21617 205 ARMSTRONG AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married "natural", or Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Ves Give Specify: WHITE 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ **ELEANOR CARRIE THOMAS** DEWEY F. JONES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1929 CAPE HORN ROAD, HAMPSTEAD, MARYLAND 21074 JETTIE IRENE SMITH/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State **SEBTo** 09 CHESTER, MARYLAND KINGSLEY CEMETERY 4 Donation 5 Other (Specify) Name and Address of Facility ILOWS, HELFENBEIN 6 SHAMROCK ROAD, Signature of Funeral Service Licensee & NEWNAM FUNERAL HOME, P.A. CHESTER, MARYLAND 21619 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or complication Interval Between Ons and Death Immediate Cause (Final Orehotu 61 Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). executed burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical The law requires that the death certificate be of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Den 1 ☐ Yes 2 ♣No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv certificate has performed Yes 2 2 🗌 No 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 SNatural 5 Pending Division 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d_Date signed (Month, Day, Year) 29b. Signa of certifie 29c. License number 182176 30. Name and add person who completed cause of death (Item 23a) (Type, Prin 2108 1)17

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day

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32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Carol Anne Crampton September 4:17A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Charles Civista Medical Center La Plata 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Min. (Month, December 1 □ M 2 🗓 F Hours Months Washington DC Director 578-48-2438 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Charles Newburg 1 🗌 Yes 2 ី No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13347 Hill Road 20664 USA should be filed within 72 hours after death and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. ğ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Adminstrative Clerk Mail Distribution Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Woodrow Harley Ruth Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Gary Crampton/Son 1961 Richard Lane, Lusby, MD 20657 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Crem. 9/6/2010 Charlotte Hall, MD Signature of Euneral Service Ligens 22 AREHART-ECHOLS FUNERAL HOME, P.A. 20646 St Mary's Plata 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest pproximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final enysician/ ECOMPAN MUTCHER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 X No ed by the a detached f 9 Unknown g Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 si autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 🗓 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA မ within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral i 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20629 September 7,2010 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Watken, M.D. Waldorf,MD 20603 George 31. Date filed (Month, Day, State UB Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sep 12, 2010 **Physician** Collins Merle 06:25 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Devlin Manor Nursing & Rehab Center Cumberland Allegany Date of Birth (Month, Day, Year) Dec 16, 1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 215-36-7529 Director MD 78 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene, 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Allegany Cumberland Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12500 My Drive, N.E. 21502 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □ ¥es 2 □ No If Yes, Give Year or Dates: **Kore**& Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □Xo Specify: <u>\$</u> 3 Widowed 4 Divorced Korean white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Dept. Housing Authority permit. Pages 1 and 2 should be filed be Department of Health and Mental Hygi Important; If item 27 is marked other any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **Howard Collins** Effie Mae (Weimer) Collins ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Collins Wife MD 21502 12500 My Drive, N.E. Cumberland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rocky Gap Veterans Cemetery 9/15/2010 Flintstone MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 23a. Part / Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** netostata disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by certificate has been sirector, page 2 should 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 □ Yes 2 🗔 🚻 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩o Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

completely

within 2 To the I

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

AJ Ballino

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar Signature

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DOU17565

29d. Date signed (Month, Day, Year) × 14. 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September Day 20°10 Physician/ 9:26p Sandra Lee Davis-Johnson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Forestville Prince George's 7704 Vineyard Drive 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 M 2 F Days Hours. Ju 140nt/3 Pay, Yor 955 55 Virginia 237 92 7782 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 □ Yes 2 □ No Prince George's Forestville 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 20747 7704 Vineyard Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 X Married Yes 2 X No b Black 1 ☐ Yes Ž☐ No Specify: If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Personnel Specialist Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Rose Majors Samuel Davis, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7704 Vineyard Dr. Forestville, MD 20747 19a. Informant's Name/Relationship (Type, Print) Walter E. Johnson/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State 9-8-2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME, 2294 Old Washington Rd Waldorf, MD 20601 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ovarian Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by KNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Be

Ph sician/ Medical Examiner ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

certificate has been signed by the attending physician irector, page 2 should be detached for use as the burial completed filled in by the funeral director, After this 24 hours after deat Funeral Director

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Certificate:

Medical

death.

within 2 To the I

1 X Natural

Accident

Suicide

		1 🗆 Yes 2 🖸
		24a. Was an autopsy performed?
25. Was case referred to medical	26. Place of Death (Check or	nly one)
examiner?		

1 ☐ Yes 2 ☐ 🔀 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 5 Pending

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 💆 Residence 6 ☐ Other (Specify) 28c. Injury at 28d. Describe how injury occurred work' 1 🗌 Yes 2 🗌 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office

	1
29a. Certifier	1 Certifying Physician: To the best of my knowledge, death or
(Check	2 Medical Examiner: On the basis of examination and/or investig
only one)	3 Certifying Nurse Practioner: To the best of my knowledge, de

cured at the time, date and place, and due to the cause(s) and manner as stated. gation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c, License number 29d. Date signed (Month, Day, Year)

Camp Springs,

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David T. Isaacs, MD

Investigation

6 Could not be

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BB10 State Registrar

31. Date filed (Month, Day, Year) 32/Registrar's Signatur SEP 08 2010

5801 Allentown Rd Ste 510

			State of Maryland / Department of Health and Mental Hygiene 1-State Registrar Certificate of Death Reg. No. 2010 2950											2000	
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	Physicia	n/	Decedent's Name (First, Middle,	Last) Barbara El	laina l	Franc					2. Date of De Septen		ayı 2Y	97 A	3. Time of Death 10:30 A M
	Medic Examin		4a. Facility Name (if not institution,				4b. City, T	own or l	Location	of Death	bepten	$\overline{}$	c. County of		10.30 A.
-	A	ei	Larkins Chase		•		4b. Oity, 1	OWII, OI	Bowi				-		eorge's
	Funeral			6. Sex 7	'. Age (In yrs.	last birthday)	If Under		If Under	24 Hrs.	8. Date of Bir		9	Rintho	lace (State or Foreign
	Director		577-68-4657	1 □ M 2 🖾 F	62	Yrs.	Months	Days	Hours	Min.	Aug. I	y, rear	948	Gount	DC
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	the N or 28	Dir	10e. Street and Number	000160 8			10f. Zip (Code	DOW			10g. C	itizen of Wha	at Coun	try?
	s 23a	Funeral Director	15005 Health Ce	nter Driv	nter Drive			20716					Jnited	Sta	ates
	death item ner n		11. Marital Status	edent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specorces? If Yes, specify Cuban, Mexican, Puerto R						cify Yes or No- Rican, etc.)		14. Race -	Americ White, 6		
36	after al", or xami	d by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give										Specify:		
9	hours natura ical E	Completed by	15. Decedent's Education 16a. Decedent's Us					Occupa	tion			16b.	Kind of Busin		
215	in 72 e. nan "r	dmo	(Specify only highes Elementary/Seconday (0-12)	st grade completed) College (1-4	or 5+)	life. D	kind of work O NOT use i	retired)	•		•				,,
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and	e filec ntal H ed ot even	To Be	17. Father's Name (First, Middle, La	,					18. Mothe		e (First, Middle,				
ž	vuld b d Mer mark natic		Odell Henry 19a. Informant's Name/Relationshi			1					argaret				
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Donald Adams			1					l Route Numbe San A	-			
<u>6</u>			20a. Method of Disposition			Place of Dispo	sition (Name	e of			Date		Location - Ci		
E 0	Page hent o int: If		1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (St			cemetery, cren Lee¹s (•	ent	9,2010		Clinto	n. N	Maryland
Baltimore,	permit. I Departm Importa any inju once.		21. Si a ature of Funeral Service N		+						ewart F				
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ш	Hospital or Attending Physician; The law requires that the death certificate be executed by the law requires that the death. Funeral Director. After this certificate has been signed by the attending physician and set of filled in by the funeral director, page 2 should be detached for use as the burial-fransi and set of filled in by the funeral director, page 2 should be detached for use as the burial-fransi		23a. Part 1 Enter the disease, or of shock, or heart failure. List or	complications that can ly one cause on each	omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line.									Approximate Interval Between	
			Immediate Cause (Final disease or condition Hodgkins Disease												Onset and Death Months
-			resulting in death) Due to (or as a consequence of):									Τ,	1		
		ē	Sequentially list conditions, if any, leading to immediate	D. —	b. Severe Anemia Due to (or as a consequence of):									1	ionths
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		Ĕ	that initiated events resulting in death) Last C. Due to (or as a consequence of):												
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687		Мe	IF FEMALE:												
Box 6	eath certifical attending ph I for use as th	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No								23d. Date of delivery Month Day				
ĕ	ne des the s	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unkno		death 5∟	J Other (spe	спу)							Day Year
P.O.	es that the dessigned by the s	y P	Part II. Other significant condition	ns contributing to dea	ath but not res	sulting in the u	nderlying ca	use give	en in Part I	l.	23e. Did t	obacco	use contribu	ite to th	e cause of death?
S,	n sign	ed b	Hypertension								1 🗆	Yes 2	2 ⊠ No 3	☐ Prob	ably 4 🗆 Unknown
Ö	w requires s been sig 2 should t	Completed by	Hypothyroidis	sm.								24a. Was an autopsy findir prior to completion			
Rec	The law cate has page 2 :	ĕ	J.				_				nerfo	ormed? 2 🔀 N	dea	th?	2 No
<u></u>	sician: The certificate rector, pag		25. Was case referred to medical examiner?					26. Plac	ce of Deat	th (Check					
Ş	Physicia this cert al direct	၉	1 Yes 2 A No 27. Manner of Death			ER/Outpatien			4 L2f Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)						
Division of Vital Records,	I or Attending PF after death. Director: After th d in by the funeral	Certificate:	1 ∰Natural 5 ☐ Pending	(Month,	28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 28c. Injury at work? 28d. Describe how injury occ							ry occurred			
Sio		ξĮ	2 Accident Investiga 3 Suicide 6 Could n 4 Homicide determine	ot be 280 Place of	M 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office						28f. Location (Street and Number or Rural Route Number,				Route Number
Σ	al or / s after I Dire		4 ☐ Homicide determin		building, etc. (Specify) City or Town, State)									,	
_	To the Hospital or Atter within 24 hours after de To the Funeral Direct completed filled in by the	Medical	29a. Certifier 1 Certifying I	Physician: To the besi	st of my know	ledge, death o	occured at the	ne time, o	date and p	olace, and	d due to the ca	use(s) a	ind manner a	s state	d. ise(s) and manner stated
	the Fi hin 24 the Fi mplete		only one) 3 L Certifying I	Nurse Practioner: To	the best of m	y knowledge, o	leath occurre	ed at the	time, date	and place	e, and due to th	e cause	(s) and mann	er as sta	ated.
	co Vij		29b. Signature and title of certifier				29c.	License		7			te signed (Month, Day, Year) Lember 3, 2010		
U			30. Name and address of person w	1hrt	of dooth (lt-	200\/Time_D	vint)	טטע	5143	1		Sep	tember	. J,	2010
SR	- 5		Darcy Ibitoye, I					uite	232	G1	enn Dal	.e,	Md. 2	2076	9
	Stat	е	31, Date filed (Month, Day, Year)	32. Reg	jistra 's Signa	ure de la									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5^{Day} Sept Physician/ 2010 5:30 a м **ESTES** RANDALL Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Oxon Hill 4803 Wheeler Rd. 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours May 30 , Country) 1 ፟ M 2 □ F ^YT942 LA **Director** 68 434-60-8029 Usual Residence of Decedent fshow 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location aţ Director Examiner must be notified 1 Yes 2X No 23a or 28a-f Oxon Hill MD Prince Goerges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral with 20745 USA 4803 Wheeler Rd. items filed within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?
1 △ Yes 2 □ No
If Yes, Give unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify. unk Black 3 Widowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Public Transportation 12th Metro Bus Driver Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ Ethel Goulden Rufus Estes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Oxon Hill, Md. 20745 <u>Joanne E</u>stes - Wife 4803 Wheeler Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State any injury or Metropolitan Crematorÿ9-8-2010 Alexandria, VA. 4 ☐ Donation 5 ☐ Other (Specify) Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD. 2 Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to for as a sonsequence of: if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Physician: The law requires that the death certificate be executed and -tran that initiated events Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death Yes 2 No the g 🗌 Unknown þ 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 No 3 Probably 4 Unknown 1 Yes icate has been siç ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 1 Inpatient 2 ER/Outpatient 3 IDOA ၉ 4 🗀 Nursing Home within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: To the Hospital or Attending injury Natural 5 Pending 1 Yes 2 No M Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Li Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Library Investigation of the cause of t (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year)

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State Registrar Vame and ac

ed (Month, Day, Year,

2010

completed gause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SUSAN, September **Medical** 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington Washington County Hospital Hagerstown 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min. (Month, Day, Country)
Hagerstown, 1 M 2X Director 177-42-3005 60 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Franklin Greencastle, PA 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17225 US 43 W. Baltimore St. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes No Specify: white Specify: 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) administrative asst. cabinet manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Jane Marie McAllister Carl K. Carbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17202 John A. Ecton, Jr. 7114 Grindstone Hill Rd. Chambersburg, PA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park | Sept. 17, 2010 Hagerstown,MD 21. Signature of Funeral ervice Licensee 22. Name and Address of Facility Miller-Bowersox Funeral Home Washington St. Greencastle, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physiciani disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed lifled in by the Invertal Invertal director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performe 2 🗌 No Yes 1 Yes 25. Was case referred to ledical Be 26. Place of Death (Check only one) Hospital 2 1 No Other: 1 🗀 Yes ပ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending ☐ Accident Investigation Suicide Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only (ne) 29b. Signature an

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:03 M JoAnn Elizabeth FAIR Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown . Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🛱 F Months Days Hours Min (Month, Day, Y Country)
Maryland Director 77 217-28-5706 Sept. Usual Residence of Decedent or 28a-f show filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits 1 X Yes 2 □ No Maryland Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1030 Ross Street 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the 10 0 Homemaker Her own home injury or other traumatic event, Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy
Important: If item 27 is marked ott
any injury or other traumatic accep-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Bruce G. Hull Edna Marie Zombro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colleen Kreitz - Daughter 3315 Bullfrog Road, Fairfield, Pa. 17320 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Rose Hill Cemetery 9/13/2010 Hagerstown, Maryland Signature of Funeral Service Licer 12. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ SERSIS disease or condition resulting in death)) Medical Due to (or as a consequence of): Examiner R endos; s abol, Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit + To the Hospital or Attending Physician: The law requires that the death certificate be executed 6 that initiated events resulting in death) Last Due to (or as a consequence of) DISERSE Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death signed by the a 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.
25 Funeral Director; After this certificate has t autopsy performed? 1 Yes 2 No 2 100 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 100 မ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28c. Injury at 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0060376 09 109/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mun ARID 1HED 21740 31. Date filed (Month, Day State 32. registrar's Signature

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Registrar

2010

		1	State of Maryland 1 - State Registrar		rtment of Ho tificate of D			eg. N2 0 0	29606				
	Physicia	an	1. Decedent's Name (First, Middle, Last) Ray D. Foskey				2. Date of Death Month August	24 201	3. Time of Death 2115 P M				
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death Maryland	1	4c. County of De	eath				
ad i	Funeral		Elkton Rehab. & Care Center 5. Social Security Number 6. Sex 7. Age (In yrs. las		If Under 1 Year Months Days	-			Birthplace (State or Foreign Country) Laware				
	Director		222-14-8526	Yrs.			naren 25	,1926 De	10d. Inside City Limits				
	show	'n	10a. State 10b. County 10c. City, fown of Education										
	the M	Director	DE Sussex Lau 10e. Street and Number	urer	10f. Zip Code		11	0g. Citizen of What	Country?				
	th with 23a of 1st be	al Di	11459 Laurel Road		1995			USA					
	within 72 hours after death with the Maryland nne. than "natural", or items 23a or 28a-f show item Nedical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Nidowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. Armed Forces? 14. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 16. Was Decedent Ever in U.S. Armed Forces? 17. Was Decedent Ever in U.S. Armed Forces? 18. Was Decedent Ever in U.S. Armed Forces are		Vas Decedent of His FYes, specify Cubar □Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, W	merican Indian, hite, etc. White				
		Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupa kind of work done d OO NOT use retired	uring most of work		16b. Kind of Business/Industry					
212	2 B L M	фшо	Elementary/Secondary (0-12) College (1-4or 5+)		pervisor			US Postal Service					
pu		Be	17. Father's Name (First, Middle, Last) Joseph Raymond Foskey		Name (First, Middle, Maiden Surname) Taylor Foskey								
laryi	2 shou n and M Is mai raumai	2	10a Informant's Name/Relationship (Type Print)	or, City or Town, State, Zip Code) 1 21921–7570									
Baitimore,	Pages 1 and nent of Health int: If item 27 int or other t		cen	netery, cren	sition (Name of natory or other place ws Cemete	e) !		20c. Location - City					
Balt	permit. Pages Department of Important: If it any injury or o		22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hannigan, Short, Disharoon F.H. Laurel. De. 19956										
	hysician and hysician and street price burial-transit	Examiner	23a. Part 1. Ent. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a										
P.O. Box 68/60	death certi e attending d for use a	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown d. 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal conditions 4 □ Pregnant at time of deal 9 □ Unknown	nga Did to	23d. Date of Month	Day Year							
	uires tha signed d be de	þ	Part II. Other significant conditions contributing to death but not result	ting in the u	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown								
Vital Records,	The lay ate has bage 2	Completed		24a. Was a autop perfor 1 🗆 Yes	autopsy prior to completion of cause of death?								
Vita	hysician: The his certificate I I director, page	Be	25. Was case referred to medical examiner?		Oth	- 4	th (Check only of		Specify)				
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director,	ation: To	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										
	tal or Atters after de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
	Hospi 24 hour Funer etely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	rledge, deat ion and/or in	h occurred at the till vestigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and mann date and place, and	er as stated. I due to the cause(s)				
	To the vithin To the comple	Me	29b. Signature and title of certifier P. V. ACTO D		29c. Licens	e number 2065 73	3	29d. Date signed (A	nonth, Day, Year)				
	IVA			23a) (Type,	Print)	חח 2	1921	1					
Б	Sta	ate	31. Date filed (Month, Day, Year) 32. Fegistrar's Signatu	ure	harded,		. ,						
	Regist		SEP 0.7 2010 Some	B. A	-								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPT. 2010 9:50 A. M ROSE ANNA FEAR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1<u>912</u> Hours 1 □ M 2 🛭 F JUNE 12 MARYLAND 212-30-4922 98 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2X No DELAWARE SUSSEX SELBYVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 37088 WHITETAIL DRIVE USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 ANo Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes. Give 3X Widowed 4 □ Divorced Completed WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MATRON LAW ENFORCEMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ALBERT KINZER **EMMA** LOYD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37088 WHITETAIL DRIVE, SELBYVILLE, DE. RICHARD T. RUZICKA/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Cther (Specify) BALTIMORE CEMETERY 9/9/10 BALTIMORE, MARYLAND 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Onset and Death Immediate Cause (Final Physician) torration disease or condition Medical resulting in death) Due to (as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of Cause (Disease or iinjury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last been signed by the attending physician or Attending Physician: The law requires that the death certificate beather death. 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? death? After this certificate Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No Accident
Suicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital or within 24 hours aff To the Funeral Di Medical Gertifying Physic an: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9733 MP gistrar's Signature Registrar

Amend	Ιt	cem # 1 Cecil	County He	a]+k	Dont									
10-06668	9/9	Please Type	or Print in Bla	ack In	delible lnk.	Ensure	All C	opies	Are Leg	gible.	100	0	20508	
Conrad Grapes	3	I J W Clar	e of Maryland /	Dopa		anti and	d Menta	al Hygi	ene	6	101	U	2 3 0 0 0	
		1- For State Registrar		Cer	tificate of De	ath ———				g. No.				
Physic Medical Exam		Decedent's Name (First, Middle,L							Date of Deat Month	Day Vear			ime of Death	
Bicaicai Exaii	me	Gonard V. Crapo 4a. Facility Name (if not institution, of		V.	Grapes 14b. Cit	y, Town, or L	ocation of		eptembe	mber 4, 2010 003.				
		University Hospital	,			timore					120			
Funeral		Social Security Number 6.	Sex 7. Age	(In yrs. la		nder 1 Year	_	_	Date of Birt	h(MM/D			ce (State or	
Director		213-40-2346	X M 2 F		68 Yrs. Mc	nths Days	Hours	Min. A	pr. 2	5, 1		oreign Country) MA	
any		Usual Residence of Decedent 10a, State 10b, County		10c City	Town or Location							100	I. Inside City Limits	
* ,	١.			-									Yes 2 vNo	
Maryland 28a-f show d at once.	ફ	MD Cecil 10e. Street and Number	1	Elkt		Zip Code			10	Og. Citize	n of What (
5-0036 led within 72 hours after death with the Maryland lygene. Signer than "natural", or items 23a or 28s-f sho the Medical Examiner must be notified at once.	Director	70 Connor Lane				1921				US	A			
with ms 23.	a l	11. Marital Status	Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe					ecify Yes or No- 14. Race - Ameri				Indian, Black,		
death or ited	Funeral		1 X Yes 2 No					Puerto Rica	an, etc.)	White, etc.				
s after rral",	ģ	3 Widowed 4 Divorce 15. Decedent's Education (Specify	ed If Yes, Give Year 19						Specify: W] ork done 16b. Kind of Business					
2 hour	ted	Elementary/Secondary (0-12)	College (1-4 or 5		during most of				done	16D. KI	ia of Busine	siness/industry		
036 thin 7 ne.	ompleted	12	3-11-3-11-11-11-11-11-11-11-11-11-11-11-	Mechanic							nstru	ctio	n	
21215-0036 uld be filed within 72 hours after of Mental Hygener marked other than "natural", of event, the Medical Examiner.	ပြီ	17. Father's Name (First, Middle, La	st)			18			st, Middle, M	laiden S	urname)			
2121! ould be fil Mental F marked ic event, g	m i	Glenn T. Grapes						a Kir						
Shoul shoul A ris m	ဦ	19a. Informant's Name/Relationship			19b. Mailing Addr	•					or Town, S	tate, Zip	Code)	
and 2 lealth item 2 traun		Tonya Cole/ Daughter 74 Connor Lane Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location -								cation - City	y or Towr	n, State		
imore, MD 2 Pages 1 and 2 shou ment of Health and N tant: If item 27 is n or other traumatic		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Hotts Chapel Cemetery 9/12/							2010 Romney, West Virginia					
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is minjury or other traumatic.	1.3	4 Donation 5 Other Specify: Hotts Chapel Cemetery 9/12/2010 Rolliney, west virging and Address of Facility 21. Constyre of Funeral Service Licensee 22. Name and Address of Facility R.T. Foard and Gee.									0			
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Physician /Medical												proximate Interval etween Onset and		
Examiner		Immediate Cause (Final disease or condition resulting in death) Death Death Due to (or as a consequence of):												
		Sequentially list conditions, b												
	ner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause										-		
	camin	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):												
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Box 68760, c death certificate be execut the attending physician and ed for use as the burial - tra	n/M	IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, outcome	pregnancy			Date of deli	very Day	Year					
x 6 th cert ttendir r use a	icia	1								"		,		
. BO) he deatl the att y the att	Physician/Medical								22a Did tol	bacco use contribute to the cause of death?			oues of double?	
ords, P.O. By requires that the ds been signed by the should be detached	by									Yes 2 ✓ No 3 Probably 4				
ds, equire een si ould b	Completed								24a. Was a				findings available	
e law e has t ge 2 sh	Ig m			a			death	1?	etion of cause of					
tal Rectian: The certificate ector, page		25. Was case referred to medical				26.Place o	of Death (C	heck only	1 Yes 2	No	1 🗸	Yes	2 No	
Vital F ysician: his certifi director,	To Be		Hospital: 1 🗸 Inpatien	2 E	ER/Outpatient 3	DOA O	thor:		ing Home 5 Residence 6 Other:					
Division of Vital Records, P.O. as or Attending Physician: The law requires that the and the death. The all Directors After this certificate has been signed by led in by the funeral director, page 2 should be detact	T ii	27. Manner of Death	28a. Date of Injury (Month, Day Yea Sep 4, 2010	28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?					28d. Describe how injury occurred				nick up	
ttend death. ctor:	atio	1 Natural 5 Pending 2 ✓ Accident Investiga			0702 hrs	1 Ye	es 2 🗸 N	10101	orcyccie	unver	driver collided with pick up			
Divis pital or A ours after teral Direction by	ertification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.							28f. Location (Street and Number or Rural Route Number, City or Town, State)					
lospita F hours unera	S	4 Homicide determined (Specify) Major Road / Highway Pulaski Highway at Mechanics Valley Road, Northeast, Pulaski Highway at Mechanics Valley Road, Northeast, Check pally 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										oad, Northeast,		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buni	Medical	(er:On the basis of exami and manner stated.	_									se(s)	
T. W. i.o.	Me	29b Signature and title of certifier	and manner stated.	_	7	9c. License i	number			29d. Da	te signed (ed (Month, Day, Year)		
		Mayerie me Ghell O.C.M.E.							September 5, 2010					
		30. Name and address of person who		•	•									
15+1 VA			ssistant Medical E	Cianatus			itimore, l	MD 212	U1					
Si Regis	tate trar		32. Registrar's	olynature	back									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 4, 2010 7:25 A M Harry William GOLDBERG 4c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery 5712 Tanglewood Drive Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 14 Jay, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 □ F 1917 Washington, DC 93 577-54-2204 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 □Yes 21 □No Maryland Montgomery Bethesda 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20817 5712 Tanglewood Drive 12. Was Decedent Ever in U.S. Anned Forces? 1 Myes 2 No If Yes, Give Year or Dates: WW II 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married white 1 □Yes 2 No Specify. Specify: 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Civil Litigation Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lena Effenbach Abraham Goldberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5751 SW 9th St., Plantation, FL 33317 19a. Informant's Name/Relationship (Type. Print) Lisa Goldberg, Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 09/06/10 Olney, MD 21. Signatur of Yuna al Service to the าชานาทร์หรูระหยังพัยพ Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Years a Metastatic Prostate Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

Director

Funeral

Completed by

Be

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the Maryland

Pages 1 and 2 should be filed within 72 hours after death with Innent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

th and Mental Hygiene.
7 is marked other than "natural", or items: traumatic event, the Medical Examiner mu

Health a item 27

Department of Important: If it any injury or o once.

physician and s the burial-trans attending pl sate has been signed by the page 2 should be detached funeral director, After

Physician/Medical Examiner 2 Completed Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, after death Director: / d in by the f i 24 hours after e Funeral Dire letely filled in b within 24 ho

To the Fune

completely f

State

31. Date filed (Month, Day, Year) SEP 0 8 2010

25. Was case referred to medical examiner?

1∐Yes 2∭XNo

27. Manner of Death

1 Natural

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3 Suicide

29a, Certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Philip G. Henjum, M.D., 18109 Prince Philip Drive, #200, Olney, MD

Hospital:

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day, Year)

and manner stated.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number September 5, 2010 D 0035045

26. Place of Death (Check only one)

24a. Was an performed? 1 □ Yes 2 🗖 No

Other: 4 Nursing Home 5 Nesidence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

32. Registrar's Signature

Registrar

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death State Reg. No. 0 0 2 9 6 0											
	Physicia Medic		1. Decedent's Name (First, Middle, Las John K.	Gilber	ct					2 5	Date of Death	, 2 :01	O Year	3. Time of Death
9	Examir		4a. Facility Name (if not institution, give Somerford Assi	street and number	iving		4b. City, To	wn, or Lo	bia	Death		4c. Cou	oward	
	Funeral Director			ex	Age (In yrs. Ia 7 3		If Under 1 Months					9. Birthplace (State or Fo		
	laryland 8a-f show ified at	ector	Usual Residence of Decedent 10a. State 10b. County MD Howard			, Town or Loc							1	0d. Inside City Limits
	death with the Maryland items 23a or 28a-f sho ner must be notified at	by Funeral Director	10e. Street and Number 8220 Snowden I	River Pa	arkwa	У	10f. Zip C		045		1		of What Cour	
9800	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at	ted by Fun	11. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	?	l I	Vas Deceden Yes, specify	Cuban,	Mexican, F	n? (Specify Puerto Ric	Yes or No- an, etc.)		Race - Americ Black, White, e cify: Wh	
Maryland 21215-0036	within 72 hou giene. er than "nat the Medica	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)		r 5+)	(Give I	ent's Usual C dind of work of NOT use re Stor	done duri tired)		_			of Business Ind	1
/land	d be filed v Mental Hyg arked othe rtic event,	To Be	17. Father's Name (First, Middle, Last) Raymond Gilber	rt				18			irst, Middle, M. erite			
	nd 2 should ealth and h n 27 Is ma		19a. Informant's Name/Relationship (T) Jeannie Lohmeye		9	19b. Mailin	g Address (S 1 Pla	treet and	Number o	or Rural Ro .y	oute Number, 0 Glenwo	od , M	n, State, Zip C aryla	nd 20832
Baltimore,	permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meonee.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from Sta	te Ce	ace of Disposemetery, cremetery, cremetery	atory or other	er place)	9/	Date 03/2			on - City or To svill	
Balt	permit. Depart Import any inj		21. Signatur of the neral Service Licens	9241 Columbia Blvd.Silver S								ERVIC Sprin	E,P.A. g,Md20910	
	Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alzheimer's Disease Due to (or as a consequence of):											Approximate Interval Between Onset and Death
0	sate be executed physician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a conseque									
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ŽΙ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknown	n 2 ☐ Fetal at time of de	death 3	th 3 Ectopic pregnancy 5 Other (specify)						Date of delive	ery Day Year
ls, P.O.	uires that to n signed by uld be deta	<u>۾</u>	Part II. Other significant conditions co	_		ilting in the ui	nderlying cau	ise given	in Part I.					e cause of death?
Division of Vital Records,	The law req	Completed							·		24a. Was an autopsy perform	ed?		osy findings available impletion of cause of
ta	ician; sertific ector,	a B	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:					of Death ((Check on				
) V	Phys	유	1 ☐ Yes 2 ☐ No 1 27. Manner of Death	1 Inpa		R/Outpatien 28b. Time of					5 Resider Describe how			assisted_ Tiving
ono	ath. r: Afte	icat(1 Natural 5 Pending 2 Accident Investigation	(Month, E	lay, Year)	injury	м	Injury at work?	s 2 🗆 No	- 1	. Describe nov	rinjury occ	direc	- ,
TO US TO THE PROPERTY OF THE P							et, factory, o	ffice		28f.		ion (Street and Number or Rural Route Number, r Town, State)		
	Hosp 24 hou Funel eted fil	Medical	29a. Certifier (Check 2 Medical Examin	ner: On the basis of	examination	and/or investi	gation, in my	opinion, o	death occu	rred at the	time, date and	place, and	due to the cau	ise(s) and manner stated.
	only one) 3 Ucertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and 29b. Signature and title of certifier D56531							id piace, a	place, and due to the cause(s) and manner as 29d. Date signed (Mont Sept. 3			Day, Year)		
R	2		30. Name and address of person who c Harry Li M.I	ompleted cause of 8600	death (Item 2	23a) (Type, Pi den R	iver	Par	kway	#30	1 Col	um.bi	a.Md.	21045
	Stat Registra	~	31. Date filed (Month, Day, Year) SEP 0.8 2010	32. Regis	trar's Signatu	ire excel			-	_				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 2961 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Janice 1722 PM (gray 2010 09 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner of Maryland Med. Center University Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔽 F Months Days Hours Min West 68 Director Virginia 212-40-3032 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 22 any injury or other traumatic event, the Maryland ones. 10a, State 10c. City, Town or Location 10d, Inside City Limits Director MD Harford Edgewood 1 ☐ Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2200 Perry Avenue 21040 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? ģ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Transportation School Bus Driver 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Perry Grose Ethel Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Gray, Jr./Spouse 2200 Perry Avenue, Edgewood, MD 21040 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery crematory or other place)
Highview Mem. Gdns. 9/16/2010 Fallston, MD 4 Donation 5 Other (Specify) 21. Signature Finer I Servi 22. Name and Address of Facility C. Kober Harkins Funeral Home, Inc., Delta, PA 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, APDS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 10 days Pheumonia Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last the burial-transit attending physician and Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No has certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 💢 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Sulcide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🛱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MD 1578798310 09-10-2010

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

5.

Greene St. Baltimore

30. Name and address of person who completed cause of death (Item 2 a) (Type, Print)

Sharker

32. Re

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 3 per med cert G907 9/30/10 dk State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 27, \mathbf{P}^{M} 2010 6:30 Anna Snyder Hohl August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Worcester Berlin 10101 Hayes Landing Road Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, July 29 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year Days Hours 1 □ M 2 ☑ F PA 90 1920 177-34-7295 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example Internatible notified at once. 10a State 1 ∏Yes 2X No Director MD Worcester Berlin 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21811 10424 Dinges Road Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∏Yes 2∑No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. 2 3₺ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cora Unknown ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10424 Dinges Road - Berlin, Maryland 21811 Ronald Brunstetter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 09/02/2010 Salisbury, Maryland Salisbury Crematory 4 ☐ Domation 5 ☐ Other (Specify) 22. Name and Address of Facility Salisbury, Maryland of Funeral Service Licensee Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause **dne**ach line. Approximate interval Between Onset and Death Immediate Cause (Final Myocardial Physician disease or condition resulting in death) /Medical Due to (or as a consequence 1) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner requires that the death certificate be executed that initiated events resulting in death) Last use as the burial-tra Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☑ No ρ 4 Pregnant Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 2. No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No Physician: The 2 1 No 1 ☐ Yes 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner' Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Division of this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After t Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No М death. within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the dasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D: 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frenklin Au Siter 403 Beh 2181 morkell D.0 31. Date filed (Month, Day, Year) State SEP 07 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 14, Physician/ James Edward Herrmann, Jr. 2010 3:35 PM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Kline Hospice House Mt. Airy Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Mary land 217-20-1727 84 1926 Director May Usual Residence of Decedent 10b. County the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f s notified Maryland Frederick Frederick 1 Yes 2 No 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 0 ms 23a o Funeral with t 7935 Fingerboard Road 21704 U.S.A. items ; 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten ledic⊐l Examiner n 14. Race - American Indian, rmed Forces?

X Yes 2 \(\subseteq \) No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1944-1946 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Page 1 and 2 should be filed within 72 hour frnent of Health and Mental Hygiene. tant: If item 27 is marked other than "natur lury or other traumatic event, the Medical lury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Edward Herrmann, Sr. Mary E. Boulden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7935 Fingerboard Road, Frederick, MD 21704 Mrs. Charlotte R. Herrmann, wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Resthaven Mem. Gardens Sept. 19, 2010 Frederick, MD 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signate or neval Servic Li 22. Name and Address of Facility Keeney and Basford PA Funeral Home M00255 106 East Church St., Frederick, Approximate Interval Between Onset and Death 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a conse uence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury the bunal-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Vear Pregnant at time of death 5 Other (specify) Yes 2 No the g 🗌 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det Completed by 3 robably 4 Unknown 1 Yes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 1 🗆 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hexpice 6 Other (Specify) မ 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 8 Suicide 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

(Check

29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) September 15, 2010

2 Medical Examiner: On the basis of examination and of investigation, in my domining data decembers and due to the cause(s) and manner as stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ SEPT 2010 INGRAM 1906 ANNIE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F July 19, Year 1945 NC 65 Director 246-70-5095 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No **Glenarden** MD Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 20706 2919 Mueserbush Ct. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc δ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Specify: Black Completed 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Private Families 8th Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Annie Louise Ingram James Hawkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Glenarden, MD. 20706 Thressia Ingram – Daughter 2919 Mueserbush Ct. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot ■ Burial 2 □ Cremation 3 □ Removal from State Stewartville Cemetery 9-12-2010 Laurinburg, NC 4 Donation 5 Other (Specify) Signature Fungral Service Licensee Marshall's Funeral Home of Maryland 4308 <u>Suitland Rd.</u> Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (trysician) oronary disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth
4 Pregnant a
9 Unknown 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death the detached 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by a completed filled in by the funeral director, page 2 should be detact. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Diabetes 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 □ Yes 2 ☒ No Be 26. Place of Death (Check only one) မ 1🕰 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and tipe of certifie 29c. License number

CR 4

State Registrar SEP 0 8 2010

DHMH 17 Rev 7/2009

(Item 23a) (Type, Print)

MD

of person who completed cause of death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	/Medi Examir		4a. Facility Name (If not institution, give s			4b. City, Town,	or Location of Dea		4c. County	y of Death	
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ı	Funeral Director		5. Social Security Number 6. Sex 220-40-1925	M 2□F 7. Age (In yrs.	last birthday). Yrs.	Months Days			Year)	9. Birthr	place (State or Foreign
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	with t	2	10e. Street and Number			10f. Zip Code	21218	1	Og. Citizen of United		,
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21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heelih and Mental Hyglene. If item 27 is marked other than "naturel", or itema 23a or 28a-f ehow or other traumatic event, the Medical Examinar must be notilised at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Yes, specify Cub		Specify Yes or No- nto Rican, etc.)		ick, White,	
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Maryland	is m		19a. Informant's Name/Relationship (Type	•				ural Route Number			
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Ba	permit. Pages 1 and 2 Department of Heelth a Important: If Item 27 is any injury or other trai <u>once</u> .										yland21901
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	ding Ph h After th funeral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	iry at	28d. Describe h	ow injury occu	rred	
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			30. Name and address of person who co	npleted cause of death (Item	n 23a) (Type,	Print)					
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Amend#10c.PerFHPGC9-8-10cr Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Physician/ Medical 750 County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4nne 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth last birthday) Funeral 1 🗆 M 2 🔀 Days Min. Months Hours Director Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10d, Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b County 10c. City, Town or Location **Funeral Director** 1 Yes 2 No Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S.
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If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ⊡ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates. 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) DC Correctional Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည 1-ranklin 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Muttor 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral emple Hills 23a. Part the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one-cause on each line. Approximate Interval Between Onset and Death C MEVILS Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events signed by the attending physician and deed detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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neral Director: After the filled in by the funeral Certificate: injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) the Hospital of thin 24 hours a To the Hospital within 24 hours a To the Funeral C Medical 🗲 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number Man lame and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

10-07046 Janine Kenly Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 29617

		1- For State Registrar		Cen	tificate of i	Death		F	Reg. No.	
Physicia		Decedent's Name (First, Midd	lle,Last)			2. Date of Dea	ath Day 12 Yea	3. Time of Death		
ledical Exami	ner		G. KENLY						er 13 , 2010	10 10 nrs
		4a. Facility Name (if not institution	on, give street and nun	nber)	4k	. City, Town, or Lo	ocation of Dea	ath	4c. County of	of Death
		Upper Chesapeake H	lospital			Bel Air			Harford	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year			irth(MM/DD/YYYY	9. Birthplace (State or Foreign
Director		216-74-2497	1 M 2 X F	49	Yrs.	Months Days	Hours N	^{1in.} 10/0	06/1960	Country) MARYLAND
	Ì	Usual Residence of Decedent				<u> </u>				•
any	- [10a. State 10b. County		10c. City,	Town or Locatio	n				10d. Inside City Limits
nd show	2	MARYLAND H	ARFORD			EDGEWO C	OD O			1 X Yes 2 No
Maryland 28a-f show 1 at once.	Director	10e. Street and Number	-			10f. Zip Code			10g. Citizen of Wh	nat Country?
th the Maryland 23a or 28a-f sho notified at once.	吉	1941B EDG	EWATER DRI	VE		2104	40		UNITE	D STATES
with s 23	ᅙ	11. Marital Status		dent Ever in U.S		Decedent of Hispa				- American Indian, Black,
leath r iten	Funeral	1 Never Married 2 N	larried Armed For	ces? 2 X No	If Yes	s, specify Cuban, I	Mexican, Pue.	no Rican, etc.)	vvnite	e, etc.
after al", o	δy	3 Widowed 4 X Dir	vorced If Yes, Give Year or Dates:		1 _ \	∕es 2∑ No	specify:		Specify:	BLACK
ours		15. Decedent's Education (Spe	ecify only highest grade			s Usual Occupationst of working life. I			16b. Kind of Bu	siness/Industry
0036 within 72 hours iene. rer than "natur Medical Exam	ompleted	Elementary/Secondary (0-12)	College (1-	4 or 5+)				J J.	GT 000000	or December
vithin ene.	틹	11			PRODU	JCTION WO				NG DISTRIBUTOR
Filed y	ပ	17. Father's Name (First, Middle							Maiden Sumame))
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	HILBERT MCMUL 19a. Informant's Name/Relation:			10h Mailing			BRADLEY	mbor City or Tour	n, State, Zip Code)
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	٩	CHRISTIANNA H		מיזייבים					EAST, MI	
, MD and 2 sho ealth and em 27 is rraumati		20a. Method of Disposition	IGITIOWER() D			on (Name of ceme		Date		- City or Town, State
Ore ges 1 a of H of H		1 X Burial 2 Crematio	n 3 Removal fro	III State	rematory or othe			100/40		
Lim Pag Iment tant:		4 Donation 5 Other S		HARI		MORIAL GI		9/22/10		EEN, MARYLAND
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other it injury or other traumatic event, the Med		21. Signature of Funeral Service			22. Na L	me and Address of SCOT	FUNEF	RAL HOME	, P.A.	
332 LEWIS STREET, HAVE								C NAVRE	DE GRACI	E, MD 21078 art Approximate Interval
Physician /Medical		failure. List only one cause	on each line.			lone into			root, encon, or mo	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a			TOHE THE	Alcati	LOII		Dodui
8			b Due to (or as a	consequence of	<i>)</i> .					
	<u>ē</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):					
	miner	cause. Enter Underlying Cause (Disease or injury that initiated	С.							
ed nsit	Exa	events resulting in death) Last	Due to (or as a	consequence of):					
760, icate be executed physician and the burial - transit	g	XUNPENDED	d			155 000	10.0	10 mm		
760, Trate be of physicial the buria	/Medical	IF FEMALE:	AMENDED 2	3a,27,28 utcome of pregr	sa-f,per	ME 8908	3 10.8	.10 TT	23d. Date of	delivery
876 tificate ng phy as the	2	23b. Was decedent pregnant in t		rth		ideath 3	Ectopic preg	gnancy	Month	
Box 68 e death certif the attending ed for use as	Physician	past 12 months?		ant at time of dea	-41-	er (Specify)				
Bo e deat the at	μŞ	1 Yes 2 No 9 V Ur	9 Unkilo							
s, P.O. Boires that the de signed by the	by P	Part II. Other significant condi	tions contributing to	death but not re	sulting in the un	derlying cause giv	en in Part I.			ibute to the cause of death? Probably 4 Unknown
S, P										
ords, w requir	Completed							24a. Was		Were autopsy findings available prior to completion of cause of
eco he law te has	Ĕ		•							death? ✓ Yes 2 No
tal Rection: The certificate ector, page		25. Was case referred to medical	al			26, Place o	of Death (Che	ck only one)		
Vital Rechysician: The lathic certificate I director, page	o Be	examiner? 1 ✔ Yes 2 No	Hospital:	npatient 2	ER/Outpatient	3 DOA	other Nur	rsing Home 5	Residence 6	Other:
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the stater death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	-	27. Manner of Death	28a. Date o	of Injury	2Bb. Time of Inj	ury 2Bc. Injury	at Work?	28d. Describe	how injury occurr	red
ion tendin eath.	흲		iding EJ 0/	Day, Year) 12/10	FD 9:14	am 1 Ye	es 2 X No	unk		
rision ratter recto	ទី	= X	ouguton			, factory, office bu	ilding, etc.	28f. Location	(Street and Number	er or Rural Route Number, City
Div ital o Its aff	Certification:			reside	nce			Apt B	Edgewoo	Edgewater Dr
Hosp 24 hou Fune tely fi	ျှ	29a. Certifier 1 Certifying F	Physician: To the best							
AMENDED AMENDED Country Count								ed at the time, date	e and place, and d	due to the cause(s)
E 3 E 3	Me	29b. Signature and title of certifi		10		29c, License	number		29d. Date sign	ed (Month, Day, Year)
		Alli	Brandle	WD		O.C.M	l.E.		September	r 14, 2010
		30. Name and address of perso	n who completed cause	e of death (Item	23a)					
		Melissa Brassell, MD	Assistant Med	dical Examin	er 111 Pe	enn Street, Ba	iltimore, M	ID 21201		
	ate	31. Date filed (Month, Day Year SEP 1 5 2010		gistrar's Signatu	ake					
Regist		ADD TO 1 73 (31) 11	1 Been	44.	AL 14					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 9 Month 2010 Year Physician/ 5:30 P M 6 MARY A. KAPRAL Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES 6501 ROLLING RIDGE DRIVE CAPITOL HEIGHTS 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days MARCH 28 1 □ M 2 🛣 F WASHINGTON, 1915 Director 95 577-03-9874 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Directo 1 X Yes 2 □ No MD PRINCE GEORGES CAPITOL HEIGHTS 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral be filed within 72 hours after death with 20743 USA 6501 ROLLING RIDGE DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Specify: CAUCASIAN Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 X Widowed 4 Divorced Year or Dates of Health and Mental Hygiene.
item 27 is marked other than "natur
other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME 12TH HOUSEWIFE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, : Page 1 and 2 should be file tment of Health and Mental F tant: If item 27 is marked of မ ROBERT C. HYMAN MARY AGNES HYMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6501 ROLLING RIDGE DR., CAPITOL HEIGHTS, MD 20743 JOSEPH J. KAPRAL, JR./SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a, Method of Disposition Date Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State ARLINGTON NATIONAL 11/12/2010 ARLINGTON, VA 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility MARSHALL S FUNERAL HOME Signature of Funeral Service Licenses 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ALZHEIMER'S DISEASE Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of signed by the attending physician and be detached for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FFMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 roonths? Day 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.

To the reveal Director After this certificate has been si completed filled in by the funeral director, page 2 should be completed filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medica 26. Place of Death (Check only one) æ examiner? Other: 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5XX Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 XNatural work? 1 ☐ Yes 2 ☐ No 5 Pending М Investigation Accident Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 1 🕹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) . License numbe

State Registrar SEP 0 8 2010

30. Name and address of per

IVAN ZAMA, M.D. 9200 BASIL COURT SUITE 200 LARGO, MD 20774

son who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10b-f, 19b per inf g915 5-16-17 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death S. Month Physician/ Day 1 FRANK RAINE KEMP :55 am entembe Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Place Medica Center Charles La 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign VA • 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours 2-26-1939 1 M 2 □ F Min **Director** 224-48-3568 71 Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director 10d. Inside City Limits Prince George's LA PLATA MD. Yes 2 🗷 No Clinton 23a or 10e. Street and Number 8614 Woodyard Road 10f. Zip Code 20735 10g. Citizen of What Country? is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be Funeral TALL GRASS LANE U.S.A. 20646 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

X Yes 2 \sum No ARMY Black, White, etc. <u>Ş</u> 1 Never Married 2 XMarried 21215-0036 If Yes, Give Year or Dates. 1960-62 1 Yes 2 No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. CAR WHOLESALER AUTO DEALERSHIP 12th permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ FRANK RAINE KEMP LOUISE WACHTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mail 86 Apages of Street and Alugher Robertal Route Namber City or Town, State, Zip Code) 20735 CAROLYN KEMP-SPOUSE LA PLATA, MD. 20646 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or ourse praces

RESURPECTION CEMETERY 9-20-10 CLINTON, MD. 21. Signature of Fuderal Service Licenses . Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A.

23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M00479 Approximate Immediate Cause (Final disease or condition Physician/ 1 Cel Medical resulting in death) Due to (q Examiner Card Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine consequence of) physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (r s a consequence of) been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Monyo n 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital pital: 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of injury
(Month, Day, Year)

28b. Time of injury
injury
28c. Other: 1 Yes 2 No 2 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred 5 \square Pending Natural
Accident Natural work 1 🗌 Yes 2 🗌 No Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 1 - Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the F only one) 29b. Signature 29c. License number 29d. Date signed (Month Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) rarlene 31. Date filed (Month, Day, Year) State 32. Regis ar's Signatu

Registrar

Examiner P.O. Box 68760 Division of Vital Records.

the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar signed by the ar should I cate has this certificate within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

Physician

/Medical

Examiner

Funeral

Director

ir than "natural", or items 23a or 28a-f show the Modical Examination of the notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, I'm Manging.

Physician

/Medical

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

Be Completed by Physician/Medical Medical Certification: To

Part II. Other significant	t conditions co	23e. Did toba	23e. Did tobacco use contribute to the cause of death? 1 Pres 2 No 3 Probably 4 Unknown								
					24a. Was an autopsy performe 1 □ Yes 2 □	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No					
25. Was case referred to	medical	26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2 ☐ No		Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 🗌	ing Home 5 1 Residen	ce 6 Other (Specify)						
27. Manner of Death 1 □ Natural 5 [2 □ Accident	☐ Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28d. Describe how	28d. Describe how injury occurred						
3 ☐ Suicide 6 [4 ☐ Homicide	Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, factory)	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
		ysician: To the best of my kno iner: On the basis of examina and manner stated.				ise(s) and manner as stated. e and place, and due to the cause(s)					

29c. License number

29d. Date signed (Month, Day, Year)

State

29b. Signature and title of certified

Registrar's Signature

30. Name and address of derson who completed cause of death (Item 23a) (Type, Print)
MARY ANN MOORE, M.D., PA 300 DORCHESTER AVENUE, CAMBRIDGE, MD 21613

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

PENARD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29622 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 08-28 2010 Year Morrison Lucy Ann 4:30рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charles Genesis Waldorf Center Waldorf 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min VA Director Yrs 212-74-0910 86 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 XXYes 2 No Waldorf MD Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 50705 **NZA** 2295 Vine Hill Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced 4 Divorced Specify: Black Completed is marked other than "natu aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Julia White Sunnie Cardwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) P295 Vine Hill Ct・ュ Waldorfっ MD このより 19a. Informant's Name/Relationship (Type, Print) Thomas Morrison / Husband item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State permit. Page 1.
Department of I
Important: If its
any injury or of 1 X Burial 2 Cremation 3 Removal from State 04-03-507) Clinton, MD Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Cicer 22. Name and Address of Facility Strickland Funeral Services, P.A 20748 Allentown Rd, Camp Springs, MD 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death MONTHS Immediate Cause (Final Cancer of the Pancreas Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-tran resulting in death) Last Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? ☐ Pregnant at time of death ☐ Unknown Day 1 Yes 2 No ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 💆 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify funeral o Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) s after death. 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be the 1 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Funeral Medical 1xXCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 18545 September 1, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12070 Old Line Center Waldorf, MD 20602 Wisotsky M.D. 31. Date filed (Month, Day, Year

DHMH 17 Rev 7/2009

State

Registrar

SEP 0 8 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 4, Minerva Louise Martin 4:35 Рм 2010 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Prince George's Hillhaven Nursing Home Adelphi Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Months Days Hours Min (Month, Day, 436-28-3134 102 Louisiana February | Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's College Park 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20740 4330 Hartwick Road, Apt #415 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 X Never Married 2 Married If Yes, Give 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **5+** University of Maryland English Professor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jean Baptiste Martin Leonide Vial 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 Pleasant Avenue, #1, Portland, ME 04103 Corinne C. Martin / Niece 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Metropolitan Crematory 1 🗆 Burial 2 🛛 Cremation 3 🗀 Removal from State 9/7/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Cardiac Arrhythmia disease or condition resulting in death) Minutes

Physician Medical Examiner

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page 2

funeral director,

After this

Director: filled in by the

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Medical

10a. State

Director

Funeral

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Completed

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Examiner

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ral", or items 23a or 28a-f show Examiner must be notified at

"natural",

alth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med

permit. Page 1 and 2 should by Department of Health and Mer Important: If item 27 is mark any injury or other traumatic

be filed

Medical

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury that initiated events

Due to (or as a consequence of): Coronary Heart Disease Due to lor as a consequence of: Hypertensive Cardiovascular Disease Due to (or as a consequence of): Atrial Fibrillation

30 Years

29d. Date signed (Month. Day, Year)

9/7/2010

35 Years resulting in death) Last Physician/Medical 1 Year IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 4 ☐ Pregnant a 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Cerebrovascular Accident 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown 2 Certificate: Medical

Dysphagia			24a. Was an autopsv	24b. Were autopsy findings available prior to completion of cause of						
Vascular Dement	ia		performed? 1 ☐ Yes 2 🔀 No	death?						
25. Was case referred to medical examiner?	26. Place of Death (Check only one)									
1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	ursing Home	ome 5 Residence 6 Other (Specify)						
27. Manner of Death 1 🔀 Natural 5 🗌 Pending 2 🗎 Accident Investigation		28b. Time of injury	28c. Injury at work? 1 Yes 2		d. Describe how injury	occurred				
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	sician: To the best of my knov					d manner as stated.				

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D17843

within 24 ho

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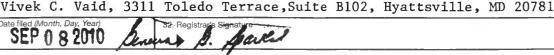
Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

SEP 0 8 2010

29b. Signature and title of certifie

only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of D September Day, 2010 6:45P. Physician/ Stephen McCall, Jr. Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Towson Gilchrist Hospice Care 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Days Min. 1 🔀 M 2 🗆 F Hours Dec. 28, 1952 Maryland 57 549-86-0182 **Director** Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at Director Ellicott City Maryland 1 🗌 Yes 2 🗹 No Howard 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number United States 21043 Funeral 6288 Woodcrest Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12 Was Decedent Ever in U.S. Armed Forces? Black, White, etc.
White þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates leted | 3 Widowed 4 Divorced 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Comp College (1,4 or,5+) Elementary/Seconday (0-12) Electronics Technical Specialist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eva Young Robert S. McCall, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynda S. McCall -wife 6288 Woodcrest Drive Ellicott City, Maryland 21043 20a. Method of Disposition
1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Metropolitan Crematory 9/2/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or compile ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ onsillar months Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic preanancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medica completed filled in by the funeral director, Be Other: 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) 잍 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funeral L Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my animal, death and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Proctioner 1. The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause a and manner as stated. (Check 3 _ Certifying Nurse Practioner To the best of my knowledge, deeth programed at the films, Unity Utia)

Statu Registrar 29b. Signature and title of certifier

SEP 0 8 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHANNES

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M)

32. Registra's Sign

29c. License number

29d. Date signed (Month, Day, Year)

TOW SUN

tember 2 2010

10-06958 Allen M. Miller Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Allen M. Miller		I- For State	State of Maryla		oartment of e <i>rtificate of</i>		d Mental H		201	0 29625
Physicia		Registrar 1. Decedent's Name (First, Mid	ldle,Last)					2. Date of Dea	th	3. Time of Death
Medical Examir	ner	Allen Martin						Septembe	Day Year er 10, 2010	1006 hrs
		4a. Facility Name (if not institut Atlantic General Hos		mber)	1	b. City, Town, or I Berlin	Location of Death	1	4c. County of Worceste	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year				Birthplace (State or Foreign Country)
Director		232-90-0278	1XM 2F	47	Yrs	Months Days	Hours Mir	5/21	/1963	WV
· iy	-	Usual Residence of Decedent 10a. State 10b. Count		Inc. Ci	ty, Town or Locati	on				10d. Inside City Limits
E B				100.01		011				1 Yes 2 X No
uylano Sa-f sh	황	MD Word	cester		Newark	10f. Zip Code		1	0g. Citizen of Wha	t Country?
the Ma a or 24	Director	7454 Worceste	er Hwy.			21841			USA	
with ms 23.	Fal	11. Marital Status	12. Was Dece			s Decedent of Hispes, specify Cuban,	panic Origin? (S			American Indian, Black,
or ite	Funeral	1 Never Married 2 X	1 Yes	2.X No				Rican, etc.)		
rs after rral", niner	≦	3 Widowed 4 D	livorced If Yes, Give Year or Dates:		1 L	Yes 2 XNo	<u> </u>	work done	Specify: 16b. Kind of Busin	white
2 hour	Completed	Elementary/Secondary (0-12				ost of working life.				,
036 ithin 7 me, r than	gu		5+		Tea	acher			Educat	ion
MD 21215-0036 of 2 should be filed within 7 ath and Mental Hygiene. m 27 is marked other than aumatic event, the Medica		17. Father's Name (First, Middl	e, Last)		_	1		,	Maiden Surname)	
121 Id be f Aental narke event,	B	Robert Miller 19a. Informant's Name/Relation	oshin (Type Print)		19h Mailing	Address (Street		Salmon	S mber, City or Town,	State Zin Code)
2 shou and N	의	Tanya Miller	/ wife		10				, MD 2184	
e, h l and l Health item	ı	20a. Method of Disposition				ition (Name of cen		Date	20c. Location - C	City or Town, State
mor Pages ent of nt: If		1 Burial 2 Cremation 4 Denation 5 Other	_		=	open Cren	n. 9/	13/2010	Frankfo	ord, DE
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ı	21. Signature of June 1 Service			22. N	ame and Address	of Facility Bu	rbage F	uneral Ho	ome
		23a. Part I. Enter the disease,	Unable of the state of the stat		1()8 Willia	am St.,	Berlin,	MD 21811	Approximate Interval
Physician /Medical Examiner		failure. List only one caus Immediate Cause (Final diseas or condition resulting in death)	se on each line. se a. Athero	sclero	otic Card					Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated	С							
cuted ind transit	Exa	events resulting in death) Last	Due to (or as a		·					
te be executed ysician and burial - transit	edical	X UNPENDED				g908 10-	-18–10 v	t 		
6876 certifical nding ph	ΣI	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U	the 1 Live bi	ant at time of	2 Fel	tal death 3 [ner (Specify)	Ectopic pregna	ancy	23d. Date of di Month	elivery Day Year
P.O. ss that the gned by the detache	≦	Part II. Other significant cond	itions contributing to	death but no	t resulting in the u	nderlying cause g	iven in Part I.			ute to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the arte completely filled in by the funeral director, page 2 should be detached for use	Completed							24a. Was autoj perfo 1 Yes	osy pri ormed? de	ere autopsy findings available or to completion of cause of ath? Yes 2 No
tal f	8	25. Was case referred to medic examiner?	Hospital:				of Death (Check			
f Vi Physi er this	၉	1 Yes 2 No 27. Manner of Death	28a. Date o		✓ ER/Outpatient 28b. Time of I		y at Work?	ng Home 5	Residence 6 how injury occurred	Other:
on on anding the function of functions	ion	1 se Notural	(Month,	Day, Year)			es 2 No			
vision or Attend frer death. Director: in by the f	Certification:		restigation 28e. Place	e of Injury - At	home, farm, stree	et, factory, office be	uilding, etc.	28f. Location (or Rural Route Number, City
Divis	Cel	4 Homicide	termined (Specify)							
the Ho iin 24 b the Fu			Physician: To the best caminer: On the basis of							
To the within To the comple	Medical	29b. Signature and title of certi	and manner st			29c. License		.		(Month, Day, Year)
		() M. 1/2	4		O.C.N	M.E.		September 1	11, 2010
	ļ	30. Name and address of personal Jack Titus MD. De	on who completed caus eputy Chief Medic			ın Street, Balt	imore MD 2	1201	-	
Sta	ate									
Regist	: LE	31. Date filed (Month Day Yea	5 2010 2	Enewa	ature A. As	arka				

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend Items 27&29a per med cert G907 9730/ Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August Physician/ 3¹1 2010 Velma Morris 30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Berlin Nursing & Rehabilitation Center Worcester Berlin 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months Davs Hours Min ^{Country)} Marvland **Director** 1919 220-01-7247 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Berlin Maryland Worcester 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò Examiner must be with 1 23a Funeral 9100 Reedy Cove. 21811 USA Apt. items 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No If Yes, Give Year or Dates. Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 X Widowed 4 Divorced event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) domestic homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Morris, Velma ပ Ella Peters John Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9100 Reedy Cove, Apt. 302, Berlin, MD 21811 Orilester Smith 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salishury 09/03/2010 Salishury, Maryland Crematory grature of Funeral Service Licensee 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD 21801 JOLLEY MEMORIAL CHAPEL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one c Immediate Cause (Final Denile advan Physician/ end Stace disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last pue Due to (or as a consequence of) attending physician Physician/Medical death certificate be Box 68760 the for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) ☐ Pregnant ☐ Unknown Pregnant at time of death the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed? death? 1 ☐ Yes 2 ☐ No After this certificate Yes 2 25. Was case referred to medical examiner? Physician: filled in by the funeral director, 26. Place of Death (Check only one) Vital Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Division of Certificate: 28d. Describe how injury occurred Hospital or Attending injury 1 X Natural 5 Pending 1 Yes 2 No death 2 Accident Investigation after death Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number R13513 29d. Date signed (Month, Day, Year) 29b. Signature and title q 10 ennie

Registrar

DHMH 17 Rev 7/2009

State

9715 Healthway Drive - Berlin, Maryland

21811

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Registrar's Signatu

Pennie Savage CRNP

SEP 07

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Q** Day Physician/ 2010 11:01 A M Chor Ying Ng Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Atlantic General Hospital Berlin If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** Min. Month, Day, Year Months Days Hours 81 190-62-8210 China **Director** Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 K No MD Ocean City Worcester 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ò Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a oi other traumatic event, the Medical Examiner must be i Funera 10149 Queens Circle USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣No Black, White, etc þ 1 Never Married 2 XMarried Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Asian Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Kenneth Chang / son .0149 Queens Circle, Ocean City, MD 21842 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 ☐XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other Specify) 9/3/2010 Frankford, DE Cape Henlopen Crem. 21. Signature Functi Servi Lucensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part Y. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart ailure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final BIDIONASCULLA DISENSES சாysician/ BUTTO THEROSCI disease or condition resulting in death) Medical D e to (or as a consequence of) Examiner STAGE NO Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying 4PG II the attending physician and hed for use as the burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 9/3/19/1929 that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the sempleted filled in by the funeral director, page 2 should be detached to empleted filled in by the funeral director, page 2. 9 Unknown 3xp P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown ecords, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? or Attending Physician: The law autopsy performed? 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 🔂 Natural 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15324 ODOCERNATY BUD BEXEN CASTARZDAUND EDEUIN 31. Date filed (Month: Day: Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

TOD: 1101 Cum

Sol

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			For State of Mar				/lental Hygi	ene	0 00000		
			State Registrar	Ce	rtificate of D						
	Physicia Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Nadine Eliza b	oeth Phil	1 i ppy		2. Date of Death Month	Day 1. Yea	3. Time of Death		
-	Examin		4a. Facility Name (if not institution, give street and number) Washington County Hospital	1	4b. City, Town, or Hage	Location of Death			4c. County of Death Washington		
	Funeral		5. Social Security Number 6. Sex 7. Age (III	'n yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth	9.	Birthplace (State or Foreign		
	Director		218-30-9262	74 Yrs.	Months Baye	Tiodio i iiiiii	Nov. 16	1935	Maryland		
	and show fat	ē		0c. City, Town or Lo	ocation	-			10d. Inside City Limits		
	Maryla 28a-f	Director	Penna. Franklin	Gree	ncastle				1 🔀 Yes 2 🗌 No		
	h the	al Di	10e. Street and Number		10f. Zip Code		10	g. Citizen of What	Country?		
	ns 23 ms 23 must	Funeral	250 Orchard Circle 11 Marital Status 12. Was Decedent Eve	win ILC 12	1722		noify Von or No	U.S.A.	merican Indian,		
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "hadreal", or items 23a or 28a-f show amportant: If item 27 is marked other than "hadreal Examiner must be notified at once.	Completed by Fi	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	,	 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☒ No Specify: 				white etc. White		
15-0	"2 hou "natu edical	plet	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done du	tion uring most of work	ing	16b. Kind of Busine	ess Industry		
121	within 7 giene. er than ; the M	Con	Elementary/Seconday (0-12) College (1-4 or 5+)	life. D	OO NOT use retired) Homemake	er		Home			
Maryland 21215-0036	l be filed v lental Hyg rked othe tic event,	To Be	17. Father's Name (First, Middle, Last) George Harper Wolfe	'			e (First, Middle, Ma zabeth Co				
	d 2 should be file alth and Mental H 27 is marked o er traumatic eve		19a. Informant's Name/Relationship (Type, Print) John S. Phillippy / Husband		ing Address (Street ai Orchard (
Baltimore,	Page 1 and nent of Heal int: If item : iry or other		20a. Method of Disposition 1 → Burial 2 → Cremation 3 → Removal from State 4 → Donation 5 → Other (Specify)		osition (Name of matory or other place 11 Cemeter) ry 9/10	Date 2	20c. Location - City Greencas			
Balti	permit. Page Department or Important: If any injury or once.	0 5	21. Signature of Funeral Service Licensee H. Martin Zunnerman	J~ 2	2. Name and Address Zimmerman 45 S. Car	of Facility And Son Lisle St	Funeral Greenca	Home Inc	: 17225		
	nysician/	8 19	23a. Part 1. Enter the disease, or complications that caused th shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ne death. Do not ent		, such as cardiac			Approximate Interval Between Onset and Death		
	Medical Examiner		disease or condition resulting in death) a. Due to (or as a o	insequence of):	NGPSTIV	14	7 FA	1:12F	MANTOLC		
	red nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury		Ellin	15	(17)	10104	UFAZC		
0	ate be executed physician and the burial-transit	dical Exa	that initiated events c. Due to (or as a co				1/6-77				
3760	ficate I g phys	/ledi	0.	*****				7			
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours atter death. The The Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Completed by Physician/Me	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of 1 ☐ Live Birth 2 ☐ 1 ☐ Live Birth 2 ☐ 1 ☐ Pregnant at tire 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	′		23d. Date of Month	delivery Day Year		
s, P.O.	ires that th signed by d be detac	d by Ph	Part II. Other significant conditions contributing to death but I	not resulting in the	underlying cause give	en în Part I.	23e. Did toba	/	e to the cause of death?		
Division of Vital Records,	sician: The law requ s certificate has beer lirector, page 2 shoul	omplete					24a. Was an autopsy perform	prior death	autopsy findings available to completion of cause of n? Yes 2 \square No		
<u>e</u>	an: Ti tifical tor, pa	Be C	25. Was case referred to medical		26. Pla	ce of Death (Chec	1 L Yes 2 k only one)	NO I	res 2 🗆 No		
ξ	Physician: The lav r this certificate has aral director, page 2	To E		2 ER/Outpatie		" 4 ☐ Nursing H	ome 5 🗆 Resider	nce 6 Other (S)	pecify)		
n of	ding Pl th. After th funera		27. Manne of Death 1	(ear) 28b. Time o	work?		28d. Describe hov	v injury occurred			
Divisio	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Certificate:	3 Sucicide 6 Could not be determined 28e. Place of Injury building, etc. (8				28f. Location (Stre City or Town,		Rural Route Number,		
_	ne Hospita n 24 hours ne Funera pleted fille	Medical	29a. Certified 1 Certifying Physician: To the best of my (Chorik 2 Medical Examiner: On the base of examon of the base of examon on the base of examon of examon on the base of examon on the base of examon of examon of examon on the base of examon of examon on the base of examon o	mination and/or inves	stigation, in my opinior	n, death occurred a	t the time, date and	place, and due to t	he cause(s) and manner stated.		
	To the within the complete of		29b. Signature and title of certifier	00514	29c. License	number 77704	3	Od. Date signed (Mo	onth, Day, Year)		
			30. Name and wdress of person who completed cause of deat	th (Item 23a) (Type,	Print) HAG	FRC.7	UN A	no 7	1742		
	Stat Registra	te	31. Date filed (Month, Day, Year) 21 20 0 32. Register's	Signature 8.	face	01-710			· · · ·		

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 5 Physician/ Gregory Thomas Reardon 2010 12:22a M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cecil 62 Duck Hollow Dr. 8. Date of Birth
(Month, Day, Yea
July 1, 1 Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 1 □XM 2 □ F Director 189-42-8895 57 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 USA 62 Duck Hollow Dr. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No 1 Never Married 2 Married Š Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Specify: Completed 3 - Widowed 4 - Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Business CPA/ Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Beatrice Keane Meade Cahill Reardon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 62 Duck Hollow Dr. Elkton, MD 21921 Jean Reardon / wife Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ^{Date} /2010 9/11/20 ne, P.A. Rising Sun, MD R.T. Foard Funeral Home, 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service in ensee 22. Name and Address of Facility R.T. Foard and Gee 259 E. Main St. Elkton, a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a conseque Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Gruenying Cause (Disease or linjury Due to (or as a consequence of) e Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death.

• Funeral Director: After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home Hospital 1 ☐ Yes 2 🗹 No 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check within 2 only one) 29b. Signature and the of certifie 29d. Date signed (Month, Day, Year) 9.7.2010. Sachcler 5 mi D0023322 30. Name and address of person who completed cause of death (Item 23a) (Type, S. S. SACH DEV MD 126 A, E Hick S ElLETONMD 21921 25 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Antonia Reyes Sept.3, 2010 Year Physician/ 4:38p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 2026 Roanoke Street Hyattsville If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Davs Hours Min. El Salvador 198991935 217-49-7183 75 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location Hyattsville 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State MD Prince George's Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a El Salvador 2026 Roanoke Street 20782 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Yes, Give El Salvadoran Specify: White Completed 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Managery or other traumatic event the Managery in t Elementary/Seconday (0-12) Homemaker College (1-4 or 5+) Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Norberta Reyes Lorenzo Saenz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2026 Roanoke Street Hyattsville, Md 20782 Maria Reyes/Daughter 20c. Location - City or Town, State Zacatecoluca, El Salvador 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Cemeterio Central 9/12/2010 4 Donation 5 Other (Specify uneral Service PANETE PADD SERVICE, P.A. 21. Signature 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death 2yrs shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Ovarian Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Éxamine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the attending physician and the for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 XNo Month Day Year been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' After this certificate 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 XNo Other: 1 🔲 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 A Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred X Natural 5 Pending death. 1 🗌 Yeş 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be To the Funeral Director 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier

Ram Trehan M.D. 1400 Forest Glen Rd #345 Silver Spring, Md 20910 31. Date filed (Month, Day, Yea 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State

Registrar

(Check

29b. Signature and title of certifier

SEP 0 8 2010

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D33224

29d. Date signed (Month, Day, Year)

Sept.8,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month RANCES **Physician** a 8:45 AM 01-2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth Month, Day, Year Oct. 23, 1927 9. Birthplace (State or Foreign Country)
Washington, DC If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M X□F Months Days Hours 82 577-32-<u>5480</u> Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. and them 27 Is marked other than "natural", or Items 23a or 28a-f ahow 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County other traumatic event, the Mudical Examiner must be nutified at 1 Yes 2 No Maryland Montgomery Silver Spring Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3128 Gracefield Road, #412 20904 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Francis Joseph Howard Hattie Louise Palmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joseph M. Reising -son 12025 Sand Hill Manor Drive Marriottsville, Maryland 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ö permit, Page Depertment of Importent: if any Injury or once. Gate of Heaven Cemetery 9/7/2010 SilverSpring, Maryland 1 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical ructive Lung Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day jo in the past 12 menths? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 Yes 2 No 3 Probably 4 ☑Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Many of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Hospital or Attending Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident rector: 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined efter Direc 4 Homicide To the Hospital within 24 hours e To the Funerel [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0064024 INA, M.D.WA

CILIZ

State Registrar 31. Date liled (Month, Day, Year)

22. Registrar's Signature.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jo Ann Ralev Physician/ Sept. 2010 7, 12:05A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Temple Hills 3315 Huntley Square Dr. Apt C-1 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 🗆 M 2 🛣 F Min 7/970/1930 579-36-4749 Alabama Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Maryland | Prince George Temple Hills 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 20748 USA 3315 Huntley Square Dr. Apt C-1 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 A Married <u>ک</u> Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🖾 No Specify. 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked or any injury or other traumatic eve မ Gaylord Η. Lovvorn Thelma Crowell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3315 Huntley Square Dr. Apt C-1 Temple Hills, MD 20748 William K. Raley/Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Kalas Crematory 9/11/2010 Edgewater, Maryland 22. Name and Address of Facility $George\ P$. 21. Signature of Funeral Service Licenses Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, MD 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final √Physician/ disease or condition Medical resulting in death) Examiner VASCULAR ACCIDENT if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events southing in death). Examine burial-transit and resulting in death) Last attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ Month Day Year After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed? 1 ☐ Yes 2 ☐ No After this certificate e Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifical leted filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 N Residence 6 Other (Specify, မ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural Accider 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide
4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 Certifying Nurse Practioner, 70th best of thy knowledge, death date and place, and due to the ra 29b. Signature) and title of certifie 29c. License number 29d, Date signed (Month, Day, Year)

CR 6

Registrar

se of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ 12:15 AM 2010 Medical 4a. Facility Name (if not institution, give street and ocation of Death 4c. County of Death Examiner Town, o nmre BALTIMORE CITY ellede (a) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2√2 F Days 7 Month 4 Day 1 Yes 7 TEMM'Y 214-78-9876 53 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ST.MARY'S LEXINGTON PARK MD. 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ral", or items 23a o Examiner must be Funeral U.S.A. 21412 GREAT MILLS RD. 20653 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify:WHITE 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within nent of Health and Mental Hygiene. ant; If item 27 is marked other tha ury or other traumatic event, the N OWN HOME HOMEMAKER 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ JAMES ROBERT LONG ELLA LOUISE MORSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHELIA FOWLER-SISTER 11798 OAK MANOR DR. WALDORF, MD. 20601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 X Cremation 3 Removal from State ATLANTIC CREMATORY 9-14-10 GLEN BURNIE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Meral Service License M0.04RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betweer shock, or heart failure, List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death)) Medical **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death sate has been signed by the page 2 should be detached Unknown 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use ontribute to the cause of death? þ 1 🗆 Yes 2 🗹 No 3 🗆 Probably 4 🗀 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ည 1 Tes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No M 2/ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioner: To the best of my knowledge, death. decurred at the time, date and place, and due to the cause(s) and manner as states 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

d address of pa

31. Date filed (Month, Day, Year)

MM

ST. Paul ST

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Day 3 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mable G. Swann 2010 SEPTEMBER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Charles La Plata Civista Hospital Birthplace (State or Foreign Country) 8. Date of Birth Month, Day, Year) 9/14/1923 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** Days Min Months Maryland 213-24-2998 86 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
?? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Eximiner must be notified at 10a. State 1 ☐ Yes 2 X No Director Ft. Washington Maryland Prince George 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9101 Old Palmer Road 20744 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 Mar 1 Fes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Native American \$ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Proctor Rose Proctor ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Heatth and Important: If Item 27 is n any injury or other traun once. Pamela A. Stewart/Daughter 15305 Sunset Drive, Hughesville, MD 20637 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 9/10/2010 | Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service License 6160 Oxon Hill Rd. Oxon Hill, MD 20745 23a. Par . Enter the disease, or complications to the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes tal or Attending Physician: The safter death.
al Director: After this certificate of in by the funeral director, pa 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled Hospital 29a. Certifier 1 🗷 Certifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0059404

cr2

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SWANN, MABI

NAPOLEON F 31. Date filed (Month, Day, Year, SEP 0 8 2010 MAGPANTA MD

32. Registrar's Signature

August

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CIVISTA MED, CENTER

State

Registrar

5 GARRETT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Fanny STERN Physician/ September 2010 2:56 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Montgomery Hospice Casey House 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 DM 2 X F Feb. 16 Year) 1915 New Jersey Director 95 578-16-9554 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20815 United States 4450 S. Park Avenue #703 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: Specify: 3

Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Minnie Casel Joseph Lev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9208 Bardon Road, Bethesda, MD 20814 Edward Stern, Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, Judean Memorial Gardens 09/03/10 Olney, MD Torchinsky Hebrew Funeral Home MOLODY 20012 254 Carroll St., NW. Washington. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mesothelioma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 🛛 No 1 🗌 Yes 4 Nursing Home 5 Residence 6 Dother (Specify) Hospice ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d, Describe how injury occurred Certificate: 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MD D0060634 September 3, 2010

CR 10

Registrar

Bindu Joseph

SEP 0 8 2010

6001 Muncaster Mill Road, Rockville, MD

20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			. 101	State of Maryland				lental Hy	giene	210	0000
			State Registrar		Cer	tificate of D	eath		Reg. No.	JIU	29636
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of Death
	Medic	al	ROSCOE	EUGENE	S	IMMS		SEPT.	1 201		8:21 P M
	Examin	er	4a. Facility Name (if not institution, give str PRINCE GEORGE 'S H			4b. City, Town, or CHEVER				nty of Death	
	— Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	at birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt			EORGE S
	Director			M 2 □ F 77	Yrs.	Months Days	Hours Min.	(Month, Day	v, Year) 1933 -	MAR'	ritry) YI.AND
	- MC		Usual Residence of Decedent								40.1.1.1.07.15-7-
	yland -f sho ed at	Director	10a. State 10b. County		Town or Loc	ation					10d. Inside City Limits 1X☐ Yes 2 ☐ No
	e Mau r 28a notifi	Dire	MD PRINCE GEO	ORGE'S LA	NDOV <u>ER</u>	10f. Zip Code			10g. Citizen	of What Cou	
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	ems c	Funeral		2. Was Decedent Ever in U.S.	13. V	Vas Decedent of His	spanic Origin? (Spa	ecify Yes or No-	USA 14. F	lace - Ameri	can Indian,
9	ter de or it mine	by F	1 X Never Married 2 Married	Armed Forces? 1 🕅 Yes 2 □ No ARM	7	Yes, specify Cubar		Rican, etc.)		lack, White,	
ဗ္ဗ	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at , the Medical Examiner must be notified at	ted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2 ☐X[No	Specify:		Spec	ify: B	LACK
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4	ithin 7 ene. • than he M	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)		DRIVER			PRIV	ATE	
0	led wi Hygid other ent, t	Be (17. Father's Name (First, Middle, Last)		IKUCK	DKIVEK	18. Mother's Nam	e (First, Middle,	Maiden Surna	me)	
<u>la</u> n	l be filed lental Hy rked oth tic event	To	HENRY SIMMS				ISABEI	ASKIN	I		
ary	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type	, Print)	19b. Mailin	g Address (Street a	nd Number or Run	al Route Numbe	r, City or Town	, State, Zip	Code)
Σ	and 2 s Health tem 27		VERONICA E. ROBER			NORMANDY	ROAD LA	NDOVER	MARYL	AND 2	.0785
ore	e 1 ar tof H liter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State C6	metery, cren	sition (Name of natory or other plac	e) !	Date	20c. Location	-	
Ę	t. Page tment ο tant: If jury or		4 Donation 5 Other (Specify)	мр		NS CEMET					MARYLAND
Baltimore, Maryland 21215-0036	permit. Page 1 and Department of Heali Important: If item 3 any injury or other once.		21. Signature of Funeral Service Licensee	1 , 11		. Name and Addres		. B. JEI			
			23a. Part 1. Enter the disease, or complic	ations that caused the death		474 LANDO				XYLANL	Approximate
	Discontinuo (shock, or heart failure. List only one Immediate Cause (Final	cause on each line.				,	ŕ		Interval Between Onset and Death
	Ph sician/ Medical		disease or condition resulting in death)	METASTATIC Due to (or as a consequence)		RATE CANC	CER			-	
	Examiner				,						
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):						
	cuted nd ransil	Examiner	Cause (Disease or iinjury that initiated events								
	ate be executed hysician and the burial-transit	al E	resulting in death) Last	Due to (or as a conseque	ence ot):						
260	physic physic the b	edical	d.					-			
Box 687	eath certificate attending phy for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If <u>ye</u> s, outcome of <u>pr</u> egnar					23d.	Date of deli	verv
XO	atter after I for u	icial	in the past 12 months?	1 Live Birth 2 Fetal 4 Pregnant at time of de		Ectopic pregnanc Other (specify)	У			Month	Day Year
<u>.</u>	the de	hys	g Unknown	9 ∐ Unknown							
<u>G.</u>	requires that the de been signed by the should be detached	by F	Part II. Other significant conditions cont RECURRENT GASTROIN	-	-	nderlying cause giv	en in Part I.				the cause of death?
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CO	law re las be	Completed						24a. Was auto	psy		opsy findings available ompletion of cause of
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<u>ta</u>	hysician: The law nis certificate has b I director, page 2 s	Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital:		Othe	ace of Death (Chec				
<u>></u>	Physic this eral di	e 일	27. Manner of Death		28b. Time of	28c. Injury	/ at	ome 5 Residence 128d. Describe h			fy)
ä	n ding ath. r: Afte e fune	icat	1 XNatural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	M 1 🗆	? Yes 2 □ No				
Division of Vital Records, P.O.	er deg ector by th	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (S City or Tov		mber or Run	al Route Number,
<u>S</u>	italor irs aft al Dir led in			7				9			
	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical Examine	ian: To the best of my knowle r: On the basis of examination	and/or invest	igation, in my opinio	n, death occurred a	it the time, date a	and place, and	due to the c	ause(s) and manner stated.
	o the vithin 2 the o the omple	Š	only one) 3 L Certifying Nurse 29b. Signature and title of certifier.	Practioner: To the best of my	knowledge, o	29c. License	number	ce, and due to th	29d. Date sig		
	F S F O		> Babild		M.D	. D6	665	8	00	103	
~	2		30. Name and address of person who cor	npleted cause of death (Item	23a) (Type, F	rint)		-			
10	1		REXFORD A. BABILA			PARKWAY	#101A G	REENBEL	MARYI	LAND 2	0770
	Stat		SEP 0 8 2010	32. Registrar's Signatu	ire /						
	Registra	ell.	OLI U G LUIU DETO								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 205 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:17 P. 31 2010 August Beverly Civilla Sams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Center Cheverly Social Security Numbe . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 04/22/1947 Wash.,D.C. 1 🗆 M 2 🔀 Months Davs Hours 63 **Director** 578-70-6091 Usual Residence of Decedent show 10a State 10d. Inside City Limits with the Maryland 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Washington D.C. 1 🖳 Yes 2 🗌 No 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 20019 U.S.A. 3308 East Capitol St., N.E. # C death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 hours after Black 1 Yes 2X No Specify If Yes Give Completed 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Home Nursing Assistant vear Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe Joseph Chapman Alpha Civilla Perkins permit. Page 1 and 2 should the Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2301 11th St., N.W. # 326, Washington, D.C. 20001 JoAnn A. Newman/Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) injury or 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington Nat'l. Cem. 09/21/10 Ft. Myer, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc. Burroughs Ave., N.E., Washington, D.C. aru Part 4. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 4. Immediate Cause (Final Physician disease or condition Cardiac Arrhythmia Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Orderlying Cause (Disease or linjury Myasthenis Gravis Examine Due to (or as a consequence of law requires that the death certificate be executed use as the burial-transi Diabetes Mellitus- Type II and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Obesity P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? ģ Month Year Day Pregnant at time of death Yes 2 No been signed by the should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Peripheral Vascular Disease 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed? Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medica Division of Vital 26. Place of Death (Check only one) funeral director, Be examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ည 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: A perpleted filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number G

cr 2

State Registrar SEP 0 8 2010 Server 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ophnell Cumberbatch, M.D. 3001 Hospital Drive, Cheverly, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 29638 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September Christian Jaysean Salters 2010 0048 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery Sex 1 XM 2 □ F 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Sep. 5,2010 7. Age (In vrs. last birthday **Funeral** Months Days Director Sep. Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Maryland Washington County Hagerstown 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 353 Merrbaugh Dr. 21740 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. Completed by 1 X Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White/Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jayson Lamont Salters Christine Diane Zeleznik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine D. Zeleznik-mother 353 Merrbaugh Dr. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 💢 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Rose Hill Cemetery 9-10-2010 |Hagerstown, Maryland 22. Name and Address of Facility Sunature of Funeral Service Licensee Douglas A. Fiery Funeral Home 1331 Eastern BLvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final Onset and Death Fhysician/ Respiratory Failure disease or condition resulting in death) 20 mins Medical Due to (or as a consequence of) Examiner Pulmonary Hypoplasia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a use as the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death signed by the a Id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should it 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 💢 No ၉ 1 Tes 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 1 X Natural 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending (Month, Day, Year) injun within 24 hours after death. To the Funeral Director, A 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date sidned (Month, Day H45952 30. Name and a ress of pe use of death (Item 23a) (Type, Print) Downing 5H-6 Gregor MD

DHMH 17 Rev 7/2009

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Registrar

31. Date filed (Month, Day, Year)

2010

glstrar's Signature

Division of Vital Records, P.O. or Attending after death. filled in by 24 hours Hospital completely within 2 To the I the

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	1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
(check only 2 one)	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and ti	tle of certifier		29c. License number		29d. Date signed (Month, Day, Year)						
N			DE 5-000		co to 100 11 100						

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

Greens Signature 31. Date filed (Month, Day,

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20**1**0 Nicholas Antonius Tyssens September Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 17531 Cedar Lawn Dr. Washington County Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day,) Jan. 16, 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Days Hours Holland Director 212-30-8516 87 Usual Residence of Decedent or 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumait event, the Medical Examiner must be notified at traumait event, the Medical Examiner must be notified as must be notified at Director Maryland Washington County Hagerstown 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 17531 Cedar Lawn Dr. 21740 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Vinyl Siding Mfg. Co. Elementary/Seconday (0-12) College (1-4 or 5+) Warehouse Employee æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Laurentuis Tyssens Anna Marie Hendrickx Tyssens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If Item 27 is any Injury or other trau Mary Ellen Tyssens-wife <u> 17531 Cedar Lawn Dr. Hagerstown, MD 21740</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 9-8-2010 Hagerstown, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses Blvd. North Hagerstown 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final disease or condition Onset and Death Physician/ CHUDHI (Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially not conditione, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of): ed by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to coo use contribute to the cause of death? þ Hospital or Attending Physician; The law requires 24 hours after death. 1 Yes 2 🗌 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manuar of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred √ Natural work? 1 ☐ Yes 2 ☐ No 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director; Af completed filled in by the fu Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the lasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practicals: To the best of my knowledge; death conured at the time, date and place, and due to the 29b. Signature and title of certifier lana/(gp & 20x)

Registrar DHMH 17 Rev 7/2009

State

OH-L

30. Name and address of person who

2010

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DOROTHY NEIGHBORS WHITBY SEPTEMBER 2010 7:40 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death OUEEN ANNE'S CENTREVILLE CORSICA HILLS NURSING HOME Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** 1 🗆 M 2 🕱 F Hours JUNE th, 24, Year 1919 MARYLAND Director 91 213-14-1207 Usual Residence of Decedent or 28a-f show 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 ☐ Yes 2 🔀 No MD QUEEN ANNE'S QUEENSTOWN 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21658 1022 CARMICHAEL ROAD USA items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc 0 ð 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: "natural" 3 Widowed 4 Divorced WHITE Completed Year or Dates the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) MANAGER **BOOK STORE** 11 -0-Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ **ELMER NEIGHBORS** DELMA OUIMBY should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is n any injury or are 2909 KING STREET, ALEXANDRIA, VA 22302 KAY ZERWICK/ DAUGHTER altimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State SEPT. 5, 2010 CHESTERFIELD CEMETERY 4 Donation 5 Other (Specify) CENTREVILLE, MD 21617 சூர Funeral Service Licensee Signatu 22. Name and Address of Facilit FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. LIBERTY ST., CENTREVILLE, MD 21617 408 S. 23a. Part 1. Enter the disease, Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit Due to (or as a consequence of) <u>|</u> resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 as the IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? jo Month Day Year Pregnant at time of death the be detached 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 Tes 2 No Accident Investigation the 1 Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one

State Registrar 29b. Signature and title of certifie

30. Name and address of person who complete

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of death (Item 23a) (Type, Print

29c. License number

29d. Date signed (Month. Dav. Year)

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If them 27 is marked other than "natural" or frems 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must have the property.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

physician and attending been signed by the should be detached certificate has After this

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 24 hours after death B Funeral Director: within 24

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 09-01-2010 Leo Duane Weller 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince George's Fort Washington Hospital Fort Washington Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 □ F MD 84 578-34-0393 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☐ No Director Prince George's Fort Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 9918 Indian Queen Point Road 20744 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 1 Yes 2 1 1 Yes, Give A Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ▼ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Clerk Private Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leo Weller Edith Bokman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0 7 4 4 19a. Informant's Name/Relationship (Type. Print) 9923 Indian Queen Point RD.,Ft. Wash.,MD Sonia Casey/Executor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2√☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09-08-10 Riverdale Crem. Riverdale, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 20746 L. Beid MO1616 Cedar Hill FH,4111 PA Ave., Suitland, lisha 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) at 30 Allenacherchic andrice An Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 212 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗀 Inpatient ER/Outpatient 3 □ DOA Certification: To 27. Manner of Dath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No a Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11711 LIVINGSTON RD. FORT WASHINGTON MID MESBAHI MD HENGAMEH 31. Date filed (Month, Day, Year) State SEP 0 8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year atherine C :30 PM 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** St. Thomas If Under 1 Year If Under 24 Hrs Place Mars 1 72 ge (In yrs. last birthday) 4 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 577-22-7289 Yrs. Mary Director 5 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ral", or items 23a or 28a-f sh Evan inst must be notified 1 ☐Yes 2 ☐ No Directo Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2152 by Funeral 20601 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 MX No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced "natural", 1312 Completed the Madical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, II. Midge. Busy Cerge Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nelson 2 Kohert Lee VAnie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M) Waldorf Cedar Theodosia 2152 (n 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Daté 1 Burial 2 Cremation 3 Removal from State Resurrection 4 ☐ Donation 5 ☐ Other (Specify) 21. Si aturi c Funeral Service Lig 22. Name and Address of Facility MI 70658 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 23a, Part 1 Onset and Death Immediate Cause (Final disease or condition resulting in death) ARTERIOSCIERONE CANDIOVASCULAN Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami burial-trar Due to (or as a consequence of): Box 68760 attending physician The law requires that the death certificate be Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy P in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဥ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this s after death.

I Director: After this d in by the funeral d 27. Manper of Death 28a. Date of Injury (Month, Day, Year) Medical Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within ? To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number SEPTEMBER 1, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sbury led Hyattsville MJZ0789 B68

State Registrar 31. Date filed (Month, Day,

Year)

0.8

Registrar's Signature

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician: after death Director: 24 hours a Hospital

Baltimore, Maryland 21215-0036

State

within 2.

31. Date filed (Month, Day, Year) Registrar

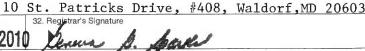
29b. Signature and title of certifier

Ashraf Meelu,M.D.

29a. Certifier

(Check only

cal



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

September 7, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPT.14, 2010 Year Physician/ 12:00P M WALLACE FRANCIS YATES Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES WALDORF GENESIS WALDORF CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F W CVAry) 577-24-6451 89 **Director** Usual Residence of Decedent or 28a-f shown notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location within 72 hours after death with the Maryland Director CHARLES LA PLATA 1 Yes 2 XNo MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a or Examiner must be i Funeral U.S.A. 20646 9780 HUNTLEY DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 XYes 2 No
If Yes, Give þ 1 Never Married 2 Married ARMY WWII 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE "natural", Completed 3 🕅 Widowed 4 □ Divorced Year or Dates the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry F.B.I. Elementary/Seconday (0-12) 1 2 th College (1-4 or 5+) FINGERPRINT TECHNICIAN U.S.GOVT. event, th Be filed permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injuy or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည VIRGINIA LEE RAMSEY WALTER YATES 19a. Informant's Name/Relationship (Type, Print)

JAMES L. YATES-SON 19b . Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $9\,7\,8\,0$ HUNTLEY DRIVE LA PLATA, MD - $2\,0\,6\,4\,6$ 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State ST. MARY S CEMETERY 9-18-10 NEWPORT, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 M00479 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau ie on each line. Approximate e on each line. Immediate Cause (Final Physician disease or condition Medical resulting in death) Due lo (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or ilnjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown į 5 Other (specify) Pregnant at time of death signed by the al 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 certificate Yes 2 KW 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After work?
1 Yes 2 No iniury 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A Investigation Accident the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O.

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 7/2009

Medical

29a. Certifie

(Check

only one)

29b. Signature and title of certifier

person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the pasis of examination investigation, in this space, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 26 per verb., g90/, 09/22/2010dhb

Certificate of Death 1 - State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ARIA VELLANEDA Month Year 2/40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 453 Oakton Road Odenton Anne Arundel Social Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/13/1931 9. Birthplace (State or Foreign 1 🗆 M 2 🗷 F Months Days Hours Min. Director 78 Yrs 578-54-9135 Colombia Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Odenton 1 Yes 2 No MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 453 Oakton Road 21113 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Yes 2 No Specify: White 1, Syes 2□No Specify: Colombian If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) and Mental Hygiene. College (1-4 or 5+) Florist Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Jacinto Avellaneda Ester Guerrero 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 453 Oakton Rd. Odenton, MD 21113 Maria E. Avellaneda, niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place). 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Uniformed Svcs Univ. 9/14/2010 Bethesda, MD 21. Signature Funeral Service Libensee 22. Name and Address of Facility M01539 any Rapp Funeral & Cremation Svcs. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ OMONAM 1 TERL SEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical $\#\mathcal{A}_{\mathcal{A}} / \mathcal{A}_{\mathcal{A}} / \mathcal{A}_{\mathcal{A}}$ Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year g 🗌 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed After this certificate 2 🗌 No nours after death.

neral Director: After this certificate
d filled in by the funeral director, pc 2. No 1 🗌 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 to Other S 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of 1 Natural 28d. Describe how injury occurred 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 21438

DHMH 17 Rev 7/2009

State

Registrar

MICHAEL J. L 31. Date filed (Month, Day, Year,

SEP 2 2 2010

DEFENSE HIGH WAY

MOLIYUI

INNAPOLII

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September Pay 13, 2010 1:10 p M Julia Applefeld Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Lutherville Genesis-Brightwood 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours May I, 1926 Mary Tand 84 **Director** 212-20-5536 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Manchester 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral U.S.A. 21102 5246 Carroll Warehime Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 💢 No 1 Never Married 2 Married If Yes, Give 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Services Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elizabeth Terzano John Randall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5246 Carroll Warehime Rd., Manchester, MD 21102 Judith Applefeld-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Baltimore, MD 4 Donation 5 Nother (Specify) Entombrent Most Holy Redeemer 9/17/10 21. Signature of Funeral Service Licensee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd.. Towson, MD 21204 Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a co Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ☐ Pregnant at time of death☐ Unknown 5 Other (specify) signed by the ard d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident A Investigation after death the Funeral Direc. Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 To the I within 2 only one) 29b. Signature and title 1010

Registrar
DHMH 17 Rev 7/2009

State

Division or Vital Records, P.O. Box 68760 hours after death uneral Director: within 24 hours a To the Funeral I Hospital completely

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

ROBERT LIBERTO

32. Registrar's Signature 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

ins

3508

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Bassler. Physician/ Month obert 9 mer 1025AM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospital Center Westminster Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Jan 8, 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) 1 X M 2 □ F Country) Marvland Director 218-36-2337 82 1928 Usual Residence of Deceden ms 23a or 28a-f show must be notified at 10b. County be filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🎛 No Maryland Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1401 New Windsor Rd. 21776 U.S.A. ural", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian or i Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 2 XNo Maryland 21215-0036 1 Yes 2 XNo Specify: 3 Divorced "natural" Completed White Year or Dates and 2 should be filed within 72 hours F Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 farmer dairy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ John Bassler Hester E. Wessel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Bassler/ wife 1401 New Windsor Rd. New Windsor, MD 21776 item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 9/21/2010 Winters Cemetery nr. New Windsor, MD 21. Signalus of Funeral Service Li 22. Name and Address of Facility Hartzler Funeral Home 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death - nd sag (schemic did my voath Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to for se's consequence of frany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Year g 🔲 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Director: After this certificate has performed 2 1 No Yes 2 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d

To the Funeral Direct

completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 139502 413 and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

447,

MD.

32. Registrar's Signature

Hosain

East Main st.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sept. 16,2010 Year 12:40 P M Nancy Jean Brouse Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Good Samaritan Hospital 5. Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 💢F Days Hours Nov. 12, 1955 Maryland Months Yrs. Director 215-68-4188 54 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Parkville Baltimore MD 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 2829 Emerald Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates white Specify. Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Flo-Tron Service Coorindator 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Katherine Anna Lang Harrison Jerome Brouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 2905 Hillcrest Avenue-Baltimore, Maryland 19a. Informant's Name/Relationship (Type, Print) Robert Chmielewski-partner 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other p Bel Air Memorial Gardens 1 Surial 2 Cremation 3 Removal from State Sept. 21, 2010 Bel Air, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services
8800 Harford Road-Parkville, Maryland 21234 ME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onget and Death Immediate Cause (Final Physician/ SEPTIC SHOC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ERFORATED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner METATASTIC To the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by ACUTE REWAL GAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed FAILURE 20 TO SEPSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 2 🚺 Yes B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Tes Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No 은 1 Dinpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 1 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

(Check

29b. Signature and title of certifier

elasinghi

Name and address of person who completed cause of death (Item 23a) (Type, Print) OCTOD STMARITAN TOSP 5 (

DHMH 17 Rev 7/2009

Registrar

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

>5601 LOCH RIVEN

29d. Date signed (Month, Day, Year)

BUND

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Joseph Bostic		1- For State Registrar	a men d	of Maryla	er Filer	cartment o G907 e <i>rtificate o</i>	f Health 7 Death	and Me H	ental Hy	giene Re	g. No. 2 1	0 29651
Physicia Medical Examin		1, Decedent's Nam	e (First, Middle,La		ph Bo	stic			1	2. Date of Deat Month Septembe	Day Year	3. Time of Death 0845 hrs
		4a. Facility Name (if not institution, gi			, <u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>	4b. City, Town		on of Death	Ocptombo	4c. County of D	Peath
Funeral		5. Social Security I		ex	7. Age (In yrs	s. last birthday)	If Under 1	Year If U	nder 24Hrs.	4	1-	. Birthplace (State or
Director		219-80-	7	X M 2 F	49	Yrs		Days Ho	urs Min.	8-13	-1961 F	oreign Country) MD
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uryland la-f shor	ctor	M D 10e. Street and Nu		na	4	15 E. I	31ddle		eet	110	g. Citizen of What (1 X Yes 2 No
h the Ma 3a or 28	I Director		Biddle	Stre	et			2120	2		US	
eath wit items 2	Funeral	11. Marital Status 1 Never Marri	ed 2 Marrie	Armed Fo	edent Ever in orces?	lf Y	as Decedent o 'es, specify Co			cify Yes or No- tican, etc.)	14. Race - A White, et	merican Indian, Black, tc.
s after d	百	3 Widowed 15. Decedent's Ed		1 Yes If Yes, Give Year or Dates:		1	Yes 2XX	•	. ,		0,000	Black
6 72 hour an "nate	Completed	Elementary/Seco	ondary (0-12)	College (1		16a. Deceder during m	ost of working	life. DO NO		d)	16b. Kind of Busine	ess/Industry
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1215 d be file fental H varked o	o Be	Lee C.				Carrie		Ja	ne G	ibson		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	۲		ostic-M								ber, City or Town, S $1 t$ o , $$ MD $$	itate, Zip Code)
Ore, ges l and of Heal if item		20a. Method of Dis 1 Burial 2	position Cremation 3	Removal fro		p. Place of Dispos crematory or ot	ner place)	cemetery,		Date	20c. Location - City	
Baltimore, sernit. Pages I ar Department of Her Important: If ite		4 Donation 5 21. Signature of Fu	Other Specify	ee		Greenn 22.N	lount lame and Add	ress of Faci		3-2010 .rch Ea	Balto, ast F/H	MD
M 링스트(E) Physician	-	23a. Part I, Enter th	e disease or com	plications that ca	used the deal					venue		MD 21202 Approximate Interval
Examiner		failure. List on Immediate Cause (ly one cause on e Final disease a	ach line.		hronic a				oopa.o., y amo	or, one or, or mount	Between Onset and Death
1		or condition resulting		Due to (or as a	consequence	of):						
	niner	if any, leading to im cause. Enter Unde	mediate rlying Cause	Due to (or as a	consequence	of):						120
ansit de	edical Examiner	(Disease or injury to events resulting in		Due to (or as a	consequence	of):						
50, tre be executed vysician and e burial - transit	dical	X UNPENDED		AMENDED 23a.2	Z.per	ME G907	9.29.1	0 TT		-		
Box 68760, e death certificate be the attending physici dor use as the buri		IF FEMALE: 23b. Was decedent past 12 months		23c. If yes, o	utcome of pre rth	egnancy 2 Fe	tal death	HE STATE OF	pic pregnanc	Ç y	23d. Date of deli Month	very Day Year
Box e death c the attented for us	Physician/N	1 Yes 2 N	lo 9 Unknow		int at time of d wn	death 5 Otl	ner (Specify)	_				
P.O.	히	Part II. Other signif	icant conditions	contributing to	death but not	resulting in the u	nderlying cau	se given in l	Part I.			e to the cause of death? Probably 4 V Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit.	Completed									24a. Was a	n 24b. Were	autopsy findings available to completion of cause of
of Vital Records, ag Physician: The law require the control of the	E									perform 1 Yes 2	ned? death	1?
Vital ysician: his certif	Re	25. Was case referr examiner? 1 ✓ Yes 2		lospital: 1 In	patient 2	ER/Outpatient		Other	h (Check on Nursing I	, ,	desidence 6 🗸 0	ther; Scene
n of viding Ph.	5	27. Manner of Death		28a. Date o	f Injury Day,Year)	28b. Time of Ir		njury at Wo	_	8d. Describe ho	ow injury occurred	
Division tal or Attendin rs after death. al Director: A led in by the fu	Certification:	2 Accident 3 Suicide	Investigati	28e Place	of Injury - At I	home, farm, stree						Rural Route Number, City
Divis lospital or At thours after d uneral Direct ly filled in by		4 Homicide	determine	(0,000,0)	of my knowle	das dasth sasur	and at the time	data and s	lace and di	or Town, Sta	(s) and manner as s	
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	one) 2 🗸	Medical Examine		examination		on, in my opir	ion, death o	occurred at the		nd place, and due to	
	Σ	29b. Signature and	title of certifier	LA 00) -			ense numbe C.M.E.	er		29d. Date signed (September 8,	
ϕ	+	30. Name and addre							D 04000			
Sta	te	Carol Allan, 31. Date filed (Month	n. Dav. Year)	nt Medical E		111 Penn S		more, M	D 21201			
Registra	_	SE	P 2 2 201) Den	me ,	1. par	Car					

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	4		For	State of N	/larylan		artment of H		ind Me	ental Hy	giene	Э		
			State Registrar			Cer	tificate of D	eath			Reg. No	.201	0 2965	2
	Physicia	n/	Decedent's Name (First, Middle, L	,	7	_				2. Date of Dea Month 09	ath Da	ay Yea		
4	Medio Examin		4a. Facility Name (if not institution, g	Car ve street and number		Brow	n 4b. City, Town, or	Location of	Death	09		S. County of D		_
and the same of	LAGIIII	CI	Union Memoria				Balto	Location of	Death		40	na.		
T	Funeral		Social Security Number 6	Sex 7. A	ge (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 2	4 Hrs.	8. Date of Birt		g.	Birthplace (State or Foreign	7
	Director		216-54-2114	1 □ M ¾ 【 X F	60	Yrs.	Months Days	Hours	IVIII.	(Month, Da 2-18			Country) MD	_
	and show at	ō	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Loc	ation						10d. Inside City Limits	_
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	r dear	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Married	12. Was Decedent	?		Vas Decedent of His Yes, specify Cuban	spanic Origin, Mexican, I	n? (Speci Puerto Ri	fy Yes or No- ca <i>n</i> , etc.)		14. Race - A Black, W	merican Indian, /hite, etc.	
036	safte ral", c Exarr	g p	3 X Widowed 4 ☐ Divorced	1 Yes 2X If Yes, Give Year or Dates.	∐ No	1	Yes 2 No	Specify:				Specify:	Black	
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lan	be file ental ked c	70	George Drumon	•			İ			First, Middle, Pinde:		Surname)		
Maryland	hould and M s mar		19a. Informant's Name/Relationship	(Type, Print)	-	19b. Mailin	g Address (Street ar					r Town, State,	Zip Code)	_
	nd 2 sealth an 27 i		Carol Brown-	Daughter			3 Ednor						•	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition XXBurial 2 Cremation 3	Removal from Stat	20b. P	lace of Dispos	sition (Name of atory or other place)	Da	te	20c. L	ocation - City	or Town, State	
tim	t. Pag tmen rtant: njury		4 ☐ Donation 5 ☐ Other (Spe	cify)	K	ing Me	emorial	Pk 9					stown, MD	
Bal	permi Depar Impol any ir		21. Signature of Fineral Service Lice	nsee		22.	Name and Address					st F/I		
			23a. Part 1. Enter the disease, or co	molications that cause	ed the death	. Do not ente	1101 E.					alto,	MD 21202 Approximate	
ú	Pnysician,		shock, or heart failure. List only Immediate Cause (Final	one cause on each li	ne.			,		,			Interval Between Onset and Death	
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٧	aath certificate be executed attending physician and for use as the burial-transit	dical Examiner	resulting in death, East		a consequ	crioc oij.								
3760	ficate g phys as the			d										_
39	ending use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnancy					23d. Date of	delivery	
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ord	v require been signal	lete								24a. Was a			autopsy findings available	_
ec	Physician: The law this certificate has al director, page 2	dmo								autop perfoi	sy rmed?	p <i>r</i> ior death	to completion of cause of	
a	ian: Ti rtifical tor, p		25. Was case referred to medical	1			26. Plac	ce of Death	(Check o	1 Yes	2 🔼 N	0 1 1 1	Yes 2 No	
ξ	hysical his ce	၉	examiner? 1 Yes 2 No	Hospital: 1 X Inpa	tient 2 🗆 [ER/Outpatient	3 DOA Other	4 ☐ Nurs	sing Home	e 5 🗆 Resid	ence 6	Other (Sp	pecify)	_
٥٥	l or Attending Ph after death. Director: After th I in by the funeral	ate:	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of inj (Month, Da		28b. Time of injury	28c. Injury a work?		- 1	d. Describe h	ow injur	y occurred		
sior	death death stor: / y the f	Certificate:	2 ☐ Accident Investigati 3 ☐ Suicide 6 ☐ Could not	be 280 Diago of Im	iun. At hor	no form atra	M 1 Y	es 2□N	_					_
Division of Vital Records,	If or A after Direct		4 ☐ Homicide determine		c. (Specify)		et, ractory, office		28	City or Tow			Rural Route Number,	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 X Certifying Ph	ysician: To the best o	f my knowle	edge, death o	ccured at the time, of	date and pla	ace, and o	due to the cau	ıse(s) ar	nd manner as	stated.	_
	To the Hos within 24 hd To the Fun completed		only one) 3 L Certifying Nu	niner: On the basis of rse Practioner: To the	examination best of my	and/or investig knowledge, de	gation, in my opinion eath occurred at the	, death occu time, date ar	urred at th nd place,	e time, date ar and due to the	nd place cause(s	, and due to the and manner	ne cause(s) and manner state as stated.	∌d.
	Neit Co		29b. Signature and title of certifier	(11A			29c. License r		01.				onth, Day, Year)	
			1910 KV110	1,00			A12	438	94	0	0	9/16	12010	_
	3		30. Name and address of person who MATO ALFREIT	completed cause of 201 E	eath (Item :	23a) (Type, Pr	int) Parkway	. Bo	a Tim	nace.	MI	217	18	
	State	е	31.Qate De OMonth Day (ear)	32. Reg. 1	ar's S		1041	9 17	//	, ,		7 - 1 -		
	Registra				7									

KE	ITH N	lice	HAEL COLLINS			
)-07205 NK UNK		Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental H		ible.	
			1- For State Certificate of Death		2010	2965
IV	Physic ledical Exam		1. Decedent's Name (First, Middle,Last) Keith Michael Collins	2. Date of Death Month September	Day Year	3. Time of Death 1817 hrs
	Caroar Exam		Keith Michael Collins 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
			NB 95 at mm 87.7, Havre de Grace, MD 21078 Havre de Grace	To Date of Birth	Harford	the least 10th the
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min		(MM/DD/YYYY) 9. Bir Foreig L959 Co	mplace (State or Maryland Juntry)
	' any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	yland	tor	MD Anne Arundel Glen Burnie	Lie	0111	1 Yes 2 No
	he Mar 1 or 28s	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Cou	ntry?
	n with t rms 23a be not	Funeral	203 1st Avenue S.W. 21061 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 1 Never Marriad 2 Marriad 12. Marriad 13. Was Decedent Forces? If Yes, specify Cuban, Mexican, Puerlo		U.S.A. 14. Race - Ameri White, etc.	ican Indian, Black,
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I filem 27 is marked other than "natural", or items 23a or 28a-f show in jury or other traumatic event, the Medical Examiner must be notified at once.	by Fun	Thever warned 2 warned 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No specify: 1 Yes 2 No specify:	rricali, etc.)	Specify: Wh:	ite
	2 hours "natur	eted b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of working life, DO NOT use retired to the control of working life, DO NOT use retired to the control of working life.		16b. Kind of Business/	ndustry
	1036 Athin 7. ene. or than	Comple	10 Construction		Steel Work	ers
	115-0 filed v al Hygi ed othe	Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name Morrache 11 H Colling	(First, Middle, Ma Trovato		
	212 ould be d Ments s mark	To B	Marshall H. Collins Dolores 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F			, Zip Code)
	MD and 2 shealth and 2 shealth and 27 is		Mrs. Dolores Call Mother 203 1st Avenue S.W. 20a. Method of Disposition (Name of cemetery,		rnie, MD 2	
	Ore, ges la t of He t: If ite		1 Burial 2 X Cremation 3 Removal from State crematory or other place)	ember		
	altim nit. Pa partmen oortani	1	1. Signature of Funeral Service Licensee 22. Name and Address of Facility C 4	2010	Glen Burni	e, MD
_			Services PA 1 2nd	Avenue S	.W. Glen B	urnie, MD
	Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line. Multiple legislation	r respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
	Examiner		Immediate Cause (Final disease or condition resulting in death) a, Multiple Injuries Due to (or as a consequence of):			
		-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
		caminer	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use to (or as a consequence of):			
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	ox 68760, ath certificate be ex attending physician or use as the burial	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 2 Fetal death 3 Ectopic pregnancy	ncy	23d. Date of delivery Month	y Day Year
	Sox 6 death cer e attendi for use	ysici	4 Pregnant at time of death 5 Other (Specify) 9 Unknown			
	that the d		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	
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	Vital In hysician: this certified director,	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursin		esidence 6 🗸 Other	: Scene
	nding Phy. th. : After the function		1 Natural 5 Rending Sep 18, 2010 1807 hrs 1 Yes 2 No	•	winjury occurred driver collided v	with a
	Division of Vital Records, P.O. Box 68760, pital or Attending Physician: The law requires that the death certificate brours after death. After this certificate has been signed by the attending physicial Director. After this certificate has been signed by the attending physicial in by the funeral director, page 2 should be detached for use as the but	Certification:	2 🗹 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	vehicle 28f. Location (Str or Town, Sta	eet and Number or Ru te) 7.7, Havre de Grace	ral Route Number, City
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		4 Homicide (Specify) Major Road / Highway 29a. Certifier (Check only one) 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one)	due to the cause(s) and manner as state	ed.
	To the Within To the comp	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mor	
			Maryana me Ukule O.C.M.E.		September 19, 2	010
3			 Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2 	21201		19.11
	Si Regis	tate	31. Date filed (Month, Day, Year) 32 Registrar's Signature 32 Registrar's Signature 33 Aregistrar's Signature 33 Aregistrar's Signature 33 Aregistrar's Signature 34 Aregistrar's Signature 34 Aregistrar's Signature 35 Aregistrar's Signature 35 Aregistrar's Signature 36 Aregistrar's Signature 37 Aregistrar's Signature 37 Aregistrar's Signature 38 Aregistra		-	
		للتحد	API MARAIA MARAIA A. M.			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ : 00 P. M Medical 10 **Examiner** Facility Name (if not institution, give str ocation of Death 4c. County of Death olumbia toward If Under 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 😿 F Months Days Hours Min. Director item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, filed within 72 hours after death with the Maryland 10a. State 10b. County Town or Location 10d. Inside City Limits Director 1 Yes 2 No towar moia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2104 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces?

1 Yes 2 No lo If Yes, Give Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗖 🔾 o Specify 3 ₩Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired) Il Hygiene. Conday (0-12) College (1-4 or 5+) Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hemportant If filem 27 is mmany injury or other s Name (First, Middle ၉ 19a. Informant's Name/Relationship (Type, Pri 19b. Mailing Add ess (Street and Number or Pural Ro<u>ute</u> Numbe 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State or other place) Burial 2 Cremation 3 Removal from State rownsville 4 Donation 5 Other (Specify) 21. Signs ure of Fune al Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Enysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year signed by the side be detached to Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Winknown Completed peen 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 DXNo Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 💹 Natural 5 Pending work' 1 Tes 2 No Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifie 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per ANA BD G908 10/05/10 Jh State of Maryland Department of Health and Mental Hygiene 2 1 1 State Per dr., g907,09/22/2010dnb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 3. Time of Death Day Physician/ Janet M. Craemer 20±0 2:20 Medical <u>September</u> 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cline Hospice House Mt. Airy Frederick If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Feb 2, Days Hours Min 1 □ M 2 🔯 F Maryland 1938 Director 72 Yrs Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD frederick Point of Rocks 10e, Street and Number 10g. Citizen of What Country? Funeral 1727 Canal Run Drive 21777 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married by 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 XDivorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 beautician cosmotology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George Johnson Isabel Virginia Plum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mark Craemer/son 1727 Canal Run Drive Point of Rocks, MD 21777 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ▼ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Korra Id S. Wades State Anatomy Board 655 W, Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition nronic resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 menths?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available 24a. Was an

Physician/ Medical Examiner

Department of Important: If it any Injury or o

Funeral

ral", or items 23a or 28a-f s Examiner must be notified

filed within 72 hours after death with the Maryland

I Hygiene.

and Mental H

Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked of

the

other traumatic

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transi Completed by ours after death. eral Director: After this certifica filled in by the funeral director, I Be Certificate: To

Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

26. Place of Death (Check only one)

autopsy performed? Yes 2	prior to completion of cause death? 1 Yes 2 No
(
Residence	6 Hother (Specific) HOSDIC

te of injury onth, Day, Year) 28b. Time of injury 28c. Injury at work? M 28c. Injury at work? 1 \[\text{Yes} 2 \subseteq \text{No} \]	Inpatient 2	ER/Outpatient	3 🗆 1	DOA 4	lome	5 ☐ Residence	6 Other
				work?	 28d	Describe how inju	ury occurred

Other:

6816

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year)

Hospital:

28a. Da (M

person who completed cause of death (Item 23a) (Type, Print 30. Name and address (ra

Year) State Registrar

25. Was case referred to medical

5 Pending

Investigation 6 Could not be

determined

examiner?
1 Yes 2 Wo

27. Manner of De th

Natural

2 Accident 3 Suicide

4 Homicide

24 hours

within 2 To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Clark 718 PM 2010 1 homas Sept Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIH University of Mamland Medical Center Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 🔀 M 2 🗆 F July 9 1942 Maryland Director 220-36-9374 68 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

The Maryland of the Maryland of the Maryland any injury or other traumatic event, the Medical Examiner must be a soor once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Perry Hall 1 🗆 Yes 2 🛛 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 Hill Circle 9536 Gun USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Yes 2 No Yes, Give Completed by 1 ☐ Yes 2 No Specify: white Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Printing/Packaging (Specify only highest grade completed) Mann-Pak Inc College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ೭ Antoinette Mazalewski John Albert Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9536 Gun Hill Circle-Perry Hall, Maryland 21236 19a. Informant's Name/Relationship (Type, Print) Nancy Clark-spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Ebenezer United
Methodist church Cem. Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. 24, 2010 Donation 5 D Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lespiratory Failure
Due to (or as a consequence of): Physician/ disease or condition **Medical** resulting in death) Examiner Sequentially list conditions, if any local to the modification cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Failure attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown cate has been siç ; page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy this certificate Yes 2 No 1 ☐ Yes 2 ☐ No Be B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No ၉ 1

✓ Inpatient 2

ER/Outpatient 3

DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending after death.

I Director: Af in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Lecritiving Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie WID (Resident 1952536674 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar MATHEW

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Baltimory

54

6REENE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dav Edythe Pauline Callahan 08:40 AM SEPTEMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TOWSON SAINT JOSEPH MEDICAL CENTER BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 29, 1921 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 😾 F Min Director 216-12-3989 89 Maryland Usual Residence of Decedent 28a-f show 10a. State or than "natural", or items 23a or 28a-f sho the Medi al Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Parkville MD 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2108 Townhill Road Apt. C. 21234 U.S.A. death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force \$ 1 Never Married 2 Married Yes 2X No Yes, Give Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White Completed 3 ♥ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry led within 72 h Hygiene. other than "no (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) C&P Telephone Telephone Operator 12 other Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Gralley Edith Mahoney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2639 Matthews Drive, Parkville, MD 21234 Gene Callahan/ Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Moreland Memorial Park Sept. 24, Parkville, MD Donation 5 Other (Specify) 2010 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility Evans Funera Chapel & Cremation Services 29a. P. rt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. 8800 HarfordRd. Parkville. Interval Between Physician. viseal e or condition r su ing in death) RESPIRATORY FAILURE 2WEEKS Medical Examiner PNERMONIA COMMUNITY ACQUIRED 2 NEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events ACUTE RENAL FAILURE INEEK that the death certificate be executed the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Year 9 Unknown 9 Unknow P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires t 24 hours after death.

Leureral Director: After this certificate has been sign eted filled in by the funeral director, page 2 should be Records, TUBERCULOSIS WITH LUNG SCARRING 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performs Yes 2 No 1 \square Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural
2 Accident
3 Suicide
4 Homicide Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 29a, Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifier D0070986 SEPTEMBER 20, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 7601 OSLERDRIVE TOWSON MARYLAND

SMITH

CATHERINE

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2013 Dinkins 110 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, or Location of Death **Examiner** NOS MHORE 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) If Under If Under 24 Hrs 7. Age (In yrs. last birthday, Security Number **Funeral** Days Hours 1 □ M 2 🔀 F Months 067-14-126 Director 24 /1924 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f show 1 Pres 2 No Funeral Director MD imore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3705 lamont 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No <u>م</u> 3 Widowed 4 □ Divorced Black marked other than "natural" Completed 7 is marked other than "nature traumatic event, I'm Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) leaning Elementary/Secondary (0-12) College_(1-4or 5+) Owner 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ harlotta Kradi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3705 Ellamont -Batto Road Ethel Harrison of Health MD 21215 27 item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If it any Injury or concept on the second of th 3 Removal from State 1 ☐ Buriai 2 ☐ Cremation Park Memorial Park: 9
22. Name and Address of Facility
Joseph A Russ
222. W. North 125/10 4 Donation 5 Dother (Specify) Enternhune ut He butus Kattimo ce Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2X ER/Outpatient 3 □ DOA Certification: To this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29b. Signature and title of co 29d. Date signed (Month, Day, Year) 30. Name and address of pers completed cause of death (Item 23a) (Type, Print) Registrar's Sig 31. Date filed (Month, Day, 32. State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

	-	For State Of Maryland State Registrar	Certificate			Reg. No. 2010	29659
Physicia		1. Decedent's Name (First, Middle, Last) Mario Antonio D'Alfons	50		2. Date of Dea Month Septemb	Dav Year	3. Time of Death 10:30 PM
Medic Examin		4a. Facility Name (if not institution, give street and number) 8825 Ashford Road		own, or Location of Death		4c. County of Deat	h
Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1		8. Date of Birt (Month, Day		thplace (State or Foreign Luctry) Abruzzi Chianico
- 10		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location		Nov.	, 1924 Suc.	10d. Inside City Limits 1 ☐ Yes 2 🔀 No
the Mar or 28a-		10e. Street and Number	10f. Zip (10g. Citizen of What Co	
ath with	Funeral	8825 Ashford Road 11. Marital Status 12. Was Decedent Ever in U.S.		1234	ecify Yes or No-	U.S.A.	rican Indian.
J036 urs after de ural", or its at Examine		1 ☐ Never Married 2 ☑ Married 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		ent of Hispanic Origin? (Sp fy Cuban, Mexican, Puerto No Specify:	Rićan, etc.)	Black, White Specify: Wh i	e, etc. Lte
re, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO NOT use r	done during most of work	king	16b. Kind of Business Lebow Bro Schonemar	others
/land Zand Zabe filed w // Mental Hygi arked othe rtic event,	To Be	17. Father's Name (First, Middle, Last) Pasquale D'Alfonso				Maiden Surname) Sulpizio	
Mary 12 should alth and N 27 is me		19a. Informant's Name/Relationship (Type, Print) Maria D'Alfonso/Wife		Street and Number or Rui			
Baltimore, permit. Page 1 and Department of Heal Important: If item 3 any injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place cerm Gar	e of Disposition (Name etery, crematory or off dens of Campter y	her place) Faith Sept	Date 20.	20c. Location - City or Rosedale,	
Baltimor permit. Page 1 Department of Important: If is any injury or once.		21. Signature of Funeral Service Licensee	22. Name and Evans	Address of Facility Funeral Charford Roa	napel &	Cremation S	Services
Ph_sician/		23a. Part 1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.	no not enter the mode	of dying, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequen		TDISEA	SP		YRS'
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	ce of):	4/1004	,		7 /
760 – C, icate be executed physician and s the burial-transit	sal Exar	that initiated events resulting in death) Last C. Due to (or as a consequen	ce of):				
- /- m =	Medical	IF FEMALE:					
ords, P.O. Box 68' requires that the death certifi been signed by the attending should be detached for use as	ysician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No g Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal d 4 Pregnant at time of dea	eath 3 Dectopic pr			23d. Date of de Month	livery Day Year
es that the signed by be detact	l by Pr	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying ca	ause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
Division of Vital Records, P.O. Hospital or Attending Physician: The law requires that the 24 hours after death. Funeral Director: After this certificate has been signed by tieted filled in by the funeral director, page 2 should be detach	Completed by Physician/N	CONCINONA BLADDIS	1		24a. Was autor perfo	an 24b. Were au prior to prior to death?	topsy findings available completion of cause of
VITAI RECC Sician: The law certificate has liector, page 2 s	Be	25. Was case referred to medical examiner?		26. Place of Death (Chec	1 Yes	2 Not 1 Ye	s 2 No
tending Physication: After this control of the trueral directions of the true al directions of trueral directions of the trueral directions of trueral direct	te: To	27. Manner of Death 28a. Date of injury 28		A Utriel 4 Nursing H		dence 6 Other (Special Other Other (Special Other Other (Special Other Other Other Other (Special Other Othe	cify)
IVISION I or Attendin after death. Director: Aft	Certificate:	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	М	1 🗆 Yes 2 🗆 No	28f. Location (S	Street and Number or Ru	ral Route Number,
Division To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the		bullaing, etc. (Speciny)	an double one word of the	ho time data and place a	City or Tow		otod
the Hos hin 24 ho the Fund npleted	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge only one) Certifying Physician: To the best of my knowledge only one onl	nd/or investigation, in mowledge, death occum	ny opinion, death occurred a red at the time, date and pla	at the time, date a	and place, and due to the e cause(s) and manner as	cause(s) and manner stated stated.
Noriti		29b. Signature and title of certifier	W D	16725	:	29d. Date signed (Mont	12010
10		30. Name and address of person who completed cause of death (Item 23)	Pa) (Type, Print)	PINSLOV	#104	BALTUR	102/237
Stat Registra		31. Date filed (Month, Day, Year) SEP 2.2.2010			·		
DHMH 17 Rev 7/20		SET BELVIO BROWN B	· parker				

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 07:55 AM SEPTEMBER FANNIE EDWARDS 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HUSP ITAL N/A BAUTIMORE AGNES SAINT 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 8–13–1938 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Months 1 □ M 2 □ XF SOUTH CAROLINA 72 241-60-6124 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it e Modical Examination must be a cuttled at 1 Yes 2 No Director MD. N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21216 USA 3418 W. NORTH AVE. Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 🗓 No þ 3 ☐ Widowed 4 🕅 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7; th and Mental Hygiene. 7 is marked other than "ns College (1-4or 5+) Elementary/Secondary (0-12) DOMESTIC HOUSEWIFE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be VETUS ROBERTS ALICE ROBERTS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun DEBORAH TIMMONS (DAUGHTER) 3418 W. NORTH AVE. BALTIMORE, MARYLAND 21217 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🕅 Burial 3 Removal from State ☐ Cremation 9-22-2010 BALTIMORE, MARYLAND KING MEMORIAL PARK 5 ☐ Other (Specify) 4 Donation D. HIBNER2. Name and Address of Facility REDD FUNERAL SERVICE VAHTANOL 21. Signature of Funeral Service 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immedia Cause (Final disease r condition resulting in death) ACIDISIS - SEVERE HOURS - DAYS **Physician** META BOLIC /Medical Due to (or as a consequence of): Examiner OBSTRUCTION DAYS - WEEKS ARGE BOWEL Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is listed exerts. Due to (or as a consequence of) Examine the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) of Vital Records, P.O. Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🔼 No 4 ☐ Pregnant at time of death 5 Other (specify) detached 9 I Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? DIABETES 24a. Was an autoosy performe 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27, Manner of Death 28d. Describe how injury occurred After Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendiwithin 24 hours after death.
To the Funeral Director: A 2 Accident completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1)007 0917 SEPTEMBER 13 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) quo CHTIN AVE -BAJAJ BHAVANDEEP MD. 21229 BALTIMORE MD. Registrar's Signati 31. Date filed (A State Registrar

DHMH 17 Rev 1/2001

EDWARDS, FANNIE

Charles Fenner State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day Y September 16, 2010 1627 hrs **Medical Examiner** Charles Lee Fenner Sr. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Johns Hopkins Hospital 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Foreign Days Director Country) 1X M 2 F 50 11/25/1959 MD ink Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10b. County Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. 1X Yes 2 No N/ABaltimore Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2000 Homewood Ave. 21218 S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White etc. 1 X Never Married 2 Married 1 ___ Yes f Yes, Give Year or Dates: 4 Divorced 1 Yes 2 No specify: Specify: Black ģ 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11th Grade Painter Duron Paints 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clayton Fenner Lorraine Harrison 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie Boyd(sister) 6445 Bushey St., Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State And Crematory F/H 09/22/10 Baltimore, MD 4 Donation 5 Other Specify 22. Name and Address of Facility
JOSEPH H. Brown Jr. 21 Signature of Funeral Service Licenses ^{22.} Hansand Address of Facility 2140 N Fulton Ave.,Baltimore,MD 21217 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Complications of cocaine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical attending physician a X UNPENDED AMENDED, 23a, PII, 27, 28a-f, per ME g909 11/17/10 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the 2 Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 V Unknown Hypertensive atherosclerotic cardiovascular Completed After this certificate has been funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available disease prior to completion of cause of death? autopsy performed? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Other Nursing Home 5 Residence 6 Other Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA 1 V Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Natural Director: d in by the f 5 Pending 24 hours after death. Fd 9/16/10 Fd 1627 hrs Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) Last Lanvale St Baltimore, MD 3 Suicide 6 X Could not be street determined To the Funeral Homicide 29a, Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 17, 2010 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 . Registrar's Signa State

DHMH 17 Rev 1/2001

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17&18 Per FH G909 10/01/10 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 20 Physician/ Year 2010 3:32 September Rosa **Fuchs** Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert 323 Rachels Way Prince Frederick Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛣 F Months Days Hours Min 05/06/1930 Germany Director 80 30-48-8588 Usual Residence of Decedent show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. The start if item 27 is marked et than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d Inside City Limits Director 1 X Yes 2 No MD Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 323 Rachels Way 20678 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Receptionist Pharmaceutical Be 17. Father's Name (First, Middle, Last)
JOseph Ludwig 18. Mother's Name (First, Middle, Maiden Surname)
Anna Eva Kreuzer J0seph ဂ္ Gotz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rachels Way, Prince Frederick, MD 20678 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to John E. Fuchs / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 09/21/2010 Hanover, Maryland 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service I 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or samplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death 2/0 Physician/ 11m(1 y2~13 disease or condition Medical resulting in death) Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death cate has been signed by the a page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N this certificate 2 🗆 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP 2 2 2010

, Vm

Paul V. Pomilla,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

046314

mo

110 Hospital Rd, Ste. 310, Prince Frederick, MD 20678

29d. Date signed (Month, Day, Year)

2

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#17perFH, G907; 9/22/2010 WS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ CLM Faison Evaene Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph Ritchey Hospice Baltimore NA If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** (Month, Day, Year) 08 - 15 - 46 1**X**XM 2 □ F Director 215-46-8253 64 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director X X Yes 2 No MD NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 3121 Normount Avenue 21216 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African Armed Forces?

1 Yes 2 No
If Yes, Give "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Specify:American 3 X Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Me Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Housing 9th Grade Barnes 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Faison Eugene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3121 Normount Avenue Baltimore, MD 21216 Desiree Harvey-Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Druidridge Cem. 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 09-27-10 Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. Street Baltimore, MD 21217 21, Signature of Funeral Service Licensee 22. Name and Address of Facility 638 N. Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or) a consequence of) Examiner Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) signed by the a d be detached f 2 🗌 No 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No After this certificate has been si uneral director, page 2 should it 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed' 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the "uners To the Hospital or Attending 1 Vatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) State

Registrar

Faisan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 23aPtI,25,27,28a-f per me,g910,12/08/2010dhb
Certificate of Death
Reg. No. 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 19, 2010 Physician/ Month Earl G. Fowler September 6:48 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore County Stella Maris Hospice Timonium Social Security Number 6. Sex 1 ■ M 2 □ F 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Feb. 22, 1919 Director 219-03-1661 91 Calvert Co., MD Usual Residence of Decedent show 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County at Director r 28a-f st notified 1 Yes 2 X No Maryland Baltimore County Timonium 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5 must be r Funeral with 1 2300 Dulaney Valley Road 21093 United States Apt. C011 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. ı "natural", or iter ledical Examiner r 11. Marital Status Armed Forces? 1

Yes 2 □ No Black, White, etc 1 Never Married 2 Married ð 1 Yes 2 No Specify: White If Yes Give Specify: Completed 3 Widowed 4 Divorced W.W.II Year or Dates. the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry 21215-(Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **N/A** Letter Carrier U.S. Postal Service is marked other aumatic event, the Be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ermit. Pat.e 1 and 2 should be file Department of Health and Mental Important If item 27 is marked only injury or other traumatic eve and Mental 2 Robert F. Fowler Mary E. Grover 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\overline{21093}$ Catherine Elizabeth (nee Gray) Fowler 2300 Dulaney Valley Road Apt.C011 Timonium,MD Baltimdre, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State (Baltimore Co.) Thursday, 1 Burial 2 Cremation 3 Removal from State Moreland Mem.Park Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sept. 23, 2010 Peaceful Alternatives Funeral & Cremetion Center, P.A. Funeral Service 2325 York Road Timonium, Maryland 21093-2215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician 7/01 disease or condition Medical resulting in death) o (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying CERTIFICATION APPROVED BY MEDICAL EXAMINER Examine Cause (Disease or linjury that initiated events resulting in death) Last the burial-trar physician and Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death 5 Other (specify) be detached 9 Unknown by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Dementia due to Head Trauma 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has autopsy perforn 1 Yes 2 No certificate Division of Vital director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 X Yes 4 Nursing Home 5 Residence 2 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) After this funeral 27. Manner of Deal 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury Natural 5 Pendina 1 X Yes 2 ☐ No Shot with88mm she11 04/12/1945 Unknown M 24 hours after death. Funeral Director; A Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined Battle Field City or Town, State)
Essen, Germany Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and

State Registrar IMMILIAM

Kot person who completed cause of death (Item 23a) Type, Print)

1. Decedent's Name (First, Middle, Last) 2. Date of Death Sept 47, Physician/ , 20YO Harold Shaw Freeman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Crownsville Mid-Atlantic of Fairfield LLC 8. Date of Birth (Month, Day, Year) March 16, 1925 Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours Min. 1 XXM 2 □ F Director Yrs 85 516-30-6095 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** MD Anne Arundel Glen Burnie, MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 406 Magnolia Rd USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married XX es 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: 3 Divorced 4 Divorced Specify Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Navy Command Master Chief US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 406 Magnolia Rd., Glen Burnie, MD 21061 Audrey Freeman 20a. Method of Disposition 20b. Place of Disposition (Name of __cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 D Burial 2 XX remation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayviæw Crematory Sept 21,2010 Baltimore, MD 21. Signa are of Funeral Service 22. Name and Address of Facility
Fink Funeral Home, P.A. Gregor Fink MO1148 426 Crain Hwy S., Glen Burnie, MD 21061 duplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the dise se, or con or heart failure. List on sho Immediate ause (Final disease or c dition resulting in dealing Physician/ 110h Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a c iahet Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months? Pregnant at time of death 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24a. Was an Yes 2 N Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Tes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural injury work? 1 🗌 Yes 2 🗆 No 5 Pending 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#30perDVR G907.9/22/2010 WS

State of Maryland / Department of Health and Mental Hygiene

amend #2 per Phy G908 19/07/10 Ja Death

1 - State Registrar

23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year) Baltimore, MD 21215 2401 Belvedere Ave.

Reg. No.

200 3. Time of Death

Birthplace (State or Foreign Country)

Black, White, etc.

White

MT

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 Yes 2XX No

12:03 P

State Registrar 4 Homicide

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Richard Stephen Rees

determined

filed (Month, Day, 32. Registrar's Signature 22

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sinai Hospital

		1 State Registrar			Departm Certific		eath			No. 2	A1.20c
Physicia Medic		Decedent's Name (First, Middle, FREDERIC	K ANDREW	GRINE				2. Date o Month Septe	mber		
Examin	ner	4a. Facility Name (if not institution, state of the state	-		4b. C		Location of Dea	ath		4c. County of Dea N/A	ath
Funeral Director		5. Social Security Number 219-78-2776		e (In yrs. last b	rthday) If Ur Yrs. Mont	der 1 Year	If Under 24 Hr Hours Mir	s. 8. Date o (Month	, Day, Yea	9. Bi	rthplace (State or Fo ountry) RYLAND
within 72 hours after death with the Maryland gjene. It than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	ូ	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Location						10d. Inside City Li
28a-f s	irect	MARYLAND N/	Α		I	BALTIM	ORE				1 X Yes 2 €
s 23a or 28a-f shovust be notified at	Funeral Director	10e. Street and Number 30 E. 25th St	2 m d 171 m		10f.	Zip Code	1218	· -	10g.	Citizen of What C	ountry?
tems ar mus	Fune	11. Marital Status	12. Was Decedent Ev	ver in U.S.	13. Was De		spanic Origin? (n, Mexican, Pue	Specify Yes or	No-	U.S.A.	
"natural", or items 23 edical Examiner must	þ	1 Never Married 2 Married 3 Married 3 Divorced	If Yes, Give Year or Dates.		1 □ Ye	s 2 XXXIIo	Specify:	erto Rican, etc.		Black, White Specify: BL.	· -
in "nat Medica	Completed	15. Decedent (Specify only highes	t grade completed)		a. Decedent's L (Give kind of life. DO NOT	work done d	ation uring most of w	orking	16b	. Kind of Business	s Industry
item 27 is marked other than "natul other traumatic event, the Medical	Col	Elementary/Seconday (0-12)	College (1-4 or 5+ 2yrs	+) 5			IONS CA	SE MGR.	Н	OME DETE	NTION
ed otr	To Be	17. Father's Name (First, Middle, La	•				18. Mother's N			en Surname)	
mark		ROBERT GRINER 19a. Informant's Name/Relationshi			h Mailing Add	ress (Street a	PARRIS			or Town, State, Z	in Code)
n 27 is er trau		Chaz Griner/Da] "		,				, Md., 2	
If iten or oth		20a. Method of Disposition 1XXBurial 2 □ Cremation			of Disposition (ery, crematory		e)	Date	20c	. Location - City o	r Town, State
Important: If ite any injury or of once.		4 ☐ Donation 5 ☐ Other (Sp. 21. Sign are of Funeral Service Lie		ARBUT	US_MEMO			24-2010	_		, MARYLAN
any i		21. Significate of Fulleral Service C	ense.		WILL	LAM C W NOR	BROWN CO TH AVEN	OMMUNII UE	Y FU	NERAL HO	ME P.A.
		23a Part 1. Enter the disease, or shock, or heart failure. List or	complications that caused ily one cause on each line.	the death. Do					y arrest,		Approximate Interval Between
ician/ edical		Immediate Cause (Final disease or condition resulting in death)	_ Ameros	schero	tic Car	dioun	salan	Dise	ase		Onset and Dea
niner		Tooding in doding	Due to (or as a		e of):						4 YEAR
#	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	ı consequence	e Oij.						
I-trans	Exan	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	consequence	e of):						
the buria	edical Examiner	, , , , , , , , , , , , , , , , , , , ,	d								_
ched for use as the burial-transit	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome o 1 Live Birth 2 4 Pregnant at 9 Unknown	of pregnancy 2 Fetal dea time of death	ath 3 🗌 Ector 5 🗌 Other	oic pregnanc r (specify)	у			23d. Date of de Month	elivery Day Yea
ned by detac	y Ph	Part II. Other significant condition			j in the underlyi	ng cause giv	en in Part I.	23e. [Did tobacc	o use contribute t	o the cause of d eat
been signed by the should be detached	ted t	HYPERTENSION	OBE	SITY				1	☐ Yes	2 No 3 F	Probably 4 Un
has be e 2 shu	mple	HYPERLIPIDEMIA	}					-	Was an autopsy	prior to	utopsy findings ava completion of caus
or, pag		25. Was case referred to medical		-0-5		26 DI-	ice of Death (Ch		performed Yes 2	No. 1 Ye	es 2 No
direct	To Be	examiner? 1 Yes 2 No	Hospital:	ent 2 ER/0	Outpatient 3	Othe			Residence	6 Other (Spe	cify)
funeral		27. Manner of Death 1,			Time of injury	28c. Injury work	?	28d. Descr	ibe how in	jury occurred	
by the	Certificate:	2 Accident Investiga 3 Suicide 8 Could not be determined.	ot be 28e. Place of Injur		farm, street, fac		Yes 2 □ No	28f. Locati	on (Street	and Number or Ru	ural Route Number,
ompleted filled in by the funeral director, page 2 s		1	building, etc.	. (Specify)				City or	Town, Sta	ate)	
eted fill	Medical	(Check 2 \(\sumeq\) Medical Ex		camination and	or investigation	, in my opinio	n, d eath occurre	d at the time, d	ate and pla	ace, and due to the	cause(s) and manne
Somple	Ž	only one) 3 L Certifying I 29b. Signature and title of certifie		nvestigation, in my opinion, death occurred at the time, date and p dge, death occurred at the time, date and place, and due to the cau 29c. License number				se(s) and manner as Date signed (Mont			
_		Aperlen	TWO			D28	3987		9	-21-2	010
		30. Name and address of person w	no completed cause of de			5 4	; 1770 4	15 0	. ~ . ~)	
	l	31. Date filed (Month, Day, Year)	- 14	ALVEK	1 51	BA	LTO, 1	1D 2	1218		
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			1. Decedent's Name (First, Middle, I						2. Date of De	eath Z	Year	3 Time of gean
	Physici /Medio		Rebecca L. Green	n					Sept.	10°,	2010	12:05 p ^M
	Examir		4a. Facility Name (If not institution, g	·			,	ocation of Death	ocpe.		ounty of Death	
			Kensington Nurs 5. Social Security Number 6.				singt	On If Under 24 Hrs.	R Data of Bir	1	ntgomery	lace (State or Foreign
	Funeral Director		579-72-8250	104005	(In yrs. last bir 32	Yrs. Months		Hours Min.	8. Date of Bit (Month, Did 3/24/1	ay, <i>Year)</i> 918	Coun	VA
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location					10	0d. Inside City Limits
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	th with	Funeral Director	3000 McComas Av	e.		20	895			USA		
	r dear	nuel	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Dece	dent of His	panic Origin? (Sp Mexican, Puerto	ecify Yes or No Rican, etc.)	o- 14	1. Race - Americ Black, White, e	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modifiel Exerciting must be notified at once.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐Yes 2★★No If Yes, Give Year or Dates:	0	1 □ Yes		Specify:			Specify: Blac	ck
5-0	72 ho natur	eted	15. Decedent's (Specify only highest)	Education	16a	. Decedent's Usu		ion ring most of work	rina	16b. Kind	d of Business/Inc	dustry
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Jore	t of h nt of h i lf ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3			f Disposition (Na ry, crematory or			Date		ation - City or To	
Baltimore,	urtmer artant ortant injury		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Signature			peake Cr		of Facility Rap			sville, Crematio	
Ba	permii Depar Impor any in		21. Signature of different Sawice Inc.	N	101539			e. Silve				
d	Physician /Medical Examiner	iner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to transcribed to the cause. Enter Underlying Cause, (Disease or injury)									Approximate Interval Between Onset and Death
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f 299	v requires that the death certifit been signed by the attending I should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 🔲 Fetal death	n 3 ☐ Ectopic 5 ☐ Other (s				23	3d. Date of delive Month	ery Day Year
8a-1	w requires tha s been signed should be def	þ	Part II. Other significant conditions	s contributing to death but	t not resulting in	n the underlying	cause giver	in Part I.		Yes 2		ne cause of death?
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₩ No I N	g Phy er this eral di	n: To	27. Manner of Death	28a. Date of Injury	y 28b.	utpatient 3 D	28c. Injury	at A IZINQUISING H	ome 5 ☐ Res 28d. Describe		Other (Special	ý)
ion	Attending ir death. ector: After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	ion (Month, Day,	Year)	1njury 2 / 10 / 7 / M	Work? 1 □ Ye		Na	101	all.	
Division	I or Atter after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At home, fa (Specify)	arm, street, factor	y, office	711E	28f. Location City or To	(Street and wn, State)	Number or Rura	al Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		Physician: To the best of saminer: On the basis of and manner stat	examination ar							
	To the within To the comple	M	29b. Signature and title of certifier	fox ck	NF	I	c. License 209705	54		Sept	signed (Month, ember 2	1, 2010
				no completed cause of de	ath (Item 23a)	(Type, Print)	n D	nice i	Rocks	riller	mD.	20805
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 2 2011	32. Registra	r's Signature	and						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day o Physician/ Month / SDAM Ella Marie Harper Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 🗓 F (Month, Day,) West Virginia Director 232-32-0104 84 1926 Sept Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 360 Gatewater Ct Unit 301 21060 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc." Black White etc. "natural", or 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Western Electric Inspection Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John George Harper Malissia Baily 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sara Jane Youngbar 7820 Telegraph Road Severn, MD 21144 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation M01220 Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician 41772 ASLDIAC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Dividito (or as a consequence of): cause. Enter Underlying Exami b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Yes 2 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2: autopsy performed? death? 1 🗆 Yes 2 🗀 No ☐ Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 ☐ No ္ရ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending ☐ Accident ☐ Suicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar DHMH 17 Rev 7/2009 only one)

31. Date filed (Month, D

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type Print)

Lindre

^{Year)} 2010

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Registrar's Signa

3 🗆 Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

Henger 20,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year SEPTEMBER 15 2010 **Physician** ALICE HAINES /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** RUXTON BALTIMORE MANOR CARE RUXTON 9. Birthplace (State or Foreign Country) W. VIRGINIA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Min. 1 □ M 2 🛣 F Days Hours 11/19/ 90 W. 232 26 7614 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Evantimer rust be notified at MD BALTIMORE 1 ☐ Yes 2 No Director PERRY HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4013 KAHLSTON ROAD Completed by Funeral 21236 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 than "natural", or 1 □Yes 2 No Specify. Specify: WHITE 3 ₩ Widowed 4 Divorced the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY MARTINS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f Mental I permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev TEDERICK KATHERINE BRANTNER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY WATSON/DAUGHTER 4013 KAHLSTON ROAD PERRY HALL, MD 21236 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State METRO CREMATORY 9/18/10 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical unud dementia. **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No the 9 Unknown 9 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 1 □Yes 2 No 2 🗆 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes ∠ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Medical 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signatu/

and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

not Towson MD21204.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 1303 CAROL HAGAN SEPTEMBER 18 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 6 - 24 - 19 54 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2 F MARYLAND 220-62-4707 56 Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ROSEDALE MD BALTIMORE 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code U.S.A. 21237 7428 BRIGHTSIDE AVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2X Married 1 ☐ Yes 2 🙀 No Specify: WHITE þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) DISABLED DISABLED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (UNKNOWN) BARRETT MARGARET MAURICE ပ 9a. Informant's Name/Relationship (Type, Print) WILLIAM J. HAGAN JR/HUSPAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7428 BRIGHTSIDE AVE ROSEDALE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9-22-2010 CATONSVILLE, MD METRO CREMATORY 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityCVACH/ROSEDALE FUNERAL HOME 21237 ROSEDALE, MD 1211 CHESACO AVE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to or as a consequence of): disease or condition resulting in death) Bilateral Sequentially list conditions, Examiner than, reading to him redic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2/140 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes patient 2 No 2 ER/Outpatient 3 DOA

Physician/Medical

Funeral

Director

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items 23a

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Department of Heali Important: If item 2 any injury or other once. injury or other

Physician

/Medical **Examiner**

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I or Attending F after death. Director; After t

24 hours a Funeral L the Hospital

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traumatic event, the Medical Examiner

be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68766

Completed by Be မ Certification:

28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Accident 1 Yes 2 No Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

City or Town, State)

29b. Signature and title of certifier

4 Homicide

29a. Certifier (check only

29c. License number D0070620

SEPTEMBER 18 2010

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRISTOPHER

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

KANAKRY back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene _ State Certificate of Death 3. Time of Depth / 7:39p_M 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2010 Hunt Month Physician/ Effie Virginia August 8 Medical 4a. Facility Name (if not institution, give street and number)
2815 Fox Glove Way 4c. County of Death
Prince Georges 4b. City, Town, or Location of Death **Examiner** Marlboro Upper Social Security Number 8. Date of Birth (Month, Day, Ye Apr. 23, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** . 19<u>14</u> 1 □ M 2 🕇 F Days 96 Hours 579-24-3259 Virginia Director Apr. Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Washington N/A DC 1 X Yes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be 20010 Lamont Street, NW 612 Funeral **States** United 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ♣ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō δ 1 Never Married 2 Married 1 Yes 24 If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Colored "natural" Completed 3 X Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Domestic Engineer Elementary/Seconday (0-12) College (1-4 or 5+) Private the age 1 and 2 should be filed wit ont of Health and Mental Hygie nt: If Item 27 is marked other y or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Shaklett Marshall William Α. Sarah C. 19a. Informant's Name/Relationship (Type, Print)
Gloria E. Shaw / Niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Coda) 610 Keefer Place, NW, Washington DC 20010 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 🗷 Burial 2 🗌 Cremation 3 🔲 Removal from State permit. Page Department c Important: If any Injury or once. Lincoln Memorial Cem Aug.16, 2010 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signatu Funeral 7400 Georgia Avenue, NW, Washington DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Cardiopulmonary Arrest Medical resulting in death) Due to (or as a consequence of) Examiner Cerebrovascular Accident Sequentially list conditions, Examiner If any leading Dusi to for as a consequence of cause. Enter Underlying Cause (Disease or linjury Hypertension Physician: The law requires that the death certificate be executed burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2x No Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has completed filled in by the funeral director, page 2 secompleted filled in by the funeral director, page 2 secompleted filled in by the funeral director, page 2 secompleted filled in by the funeral director, page 2 secompleted filled in by the funeral director, page 2 secompleted filled in by the funeral director and filled in by the funeral director and filled fille autopsy performed? Yes 2 K No B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Great Niece's Other: 2 XNo 1 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Special Control of the 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 🔀 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certified 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. ;

Michael D. Cannaday,

31. Date filed (MSEP

M D19730

106 Irving Street, NW, Washington DC 20010

August 13, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date_of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. **Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them Z7 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decede. Armed Forces? Ves 2 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State q 21 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licen 16924 YORKRD, MONKTONMD 2111! that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or co shock, or heart failure. List only plications that Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner attending physician and for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗷 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? After this certificate 2 🕅 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Tes 2 🗌 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) parket. State Registrar

			State of Maryland / Dep				0 00000
				ertificate of Death		Reg. No.	0 296/3
	Physicia	ın/	1. Decedent's Name <i>(First, Middle, Last)</i> Geraldine Hines		2. Date of De Month	Dav Ye	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	<u>Beptemb</u>	er 16, 20	
	LXuIIII		Holy Cross Hospital	Silver Spring		Montgom	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 5.7.7_3.2_3.4.4.0 1 □ M 2 ☑ F 84 Yrs			h 1926 9.	Birthplace (State or Foreign
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	and show	tor	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary 28a-f otifie	Director	Maryland Prince George Ft Washin	gton			1 X Yes 2 □ No
:	a or be n		10e. Street and Number	10f. Zip Code		10g. Citizen of Wha	·
	ms 2	Funeral	2116 Trafalgar Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20744	Specify Vec on No.	United St	
920	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 3 M Widowed 4 Divorced Married Forces? 1 Yes 2 No If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 Yes 2 No Specify:	to Rican, etc.)		American Indian, Vhite, etc. 31ack
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ylan	id be tilk Mental I arked o atic eve	To E	Frank Wright	Vennie I	ame (First, Middle, Forbes	Maiden Surname)	
Mar	d 2 shou alth and 27 is m			ling Address (Street and Number or Ru Trafalgar Drive,			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to			ematory or other place) Sept	ember	20c. Location - City	
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m	an Per			1661 Good Hope Rd			
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- P	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death) End Stage Rena1 Due to (or as a consequence of):	Failure			Onset and Death
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Contract	and	Examiner	that initiated events c. Cardiopulmonary	rrest			
: 68/60 certificate be executed	physician and s the burial-transit	dical	resulting in death) Last Due to (or as a consequence of):				
3/60 figure b	g phy:		- o				
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Phys.	r this c	유	1 ☐ Yes 2 ₺ No			lence 6 Other (S	pecify)
בייולים Glipa	ath. : After	cate	1 ☒ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 Yes 2 No	Zod. Describe ii	ow injury occurred	
DIVISION OF	after des Director in by th	Certificate:	3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (S City or Tow		Rural Route Number,
D ospital	hours ineral d filled	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place,	and due to the cau	use(s) and manner as	s stated.
the H	hin 24 the Fu		(Check 2 Medical Examiner: On the basis of examination and/or inve only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	death occurred at the time, date and pla	at the time, date a lace, and due to the	nd place, and due to to cause(s) and manne	the cause(s) and manner stated. r as stated.
P	5 7 wit		29b. Signature and title of certifier / Negash Ayele, MD	29c. License number D55856		29d. Date signed <i>(M</i> September	
			30. Name and address of person who completed cause of death (Item 23a) (Type,	<u> </u>			
			1500 Forest Glen Road, Silver Spring	g MD 20910			
	State Registra		31. Date filed (Month, Day, Year) SEP 2 2 2010 32. Registrar's Signature	les l			
_							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Johnson September 2010 Herbert Leroy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore <u>Ivy Hall Geriatric Center</u> <u>Middle River</u> 9. Birthplace (State or Foreign Country) Mary Land 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1**X** M 2 □ F Months 2/1/1916 Director 212-09-1793 94 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland Examiner must be notified at Director 1 Yes 2X No Baltimore Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? or items 23a or Funeral 32 Walkern Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: "natural" 3 Divorced 4 Divorced White Year or Dates item 27 is marked other than "naturother traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene Sheet Metal Machinist Aero Space Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Richard E. Johnson Lena Kanipkamp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sl Department of Health a Important: If item 27 is <u> Agnes A. Johnson (Wife)</u> Walkern Road Essex. Maryland 21221 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State <u> 2673</u> 4 ☐ Donation 5 ☐ Other (Specify) Overlea, Maryland of Faith Mem. Gard Gardens 21, Signature of Funeral Service Licenses 22. Name and Address of Facility Home PA Bruzdzinski Funeral 1407 Old Eastern Av Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ₹1iysician/ Month disease or condition resulting in death) Congestive Cardiomyopathy Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Atrial Fibrillation 24a. Was an page 2 s autopsy performed?

1 Yes 2 X No certificate | Atheroscleratic Vascular Disease 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 M Nursing Home 5 - Residence 6 - Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 I After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check з 🗍 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9/21/2010 H 35593 30. Name and address of person who completed care of death (Item 23a) (Type, Print)

State Registrar Baltimore, MD 21221

Mace

John Loh

SEP 2 2 2010

31. Date filed (Month, Dav. Year)

Avenue

		POI	•	ealth and Mental Hy	giene	
		State Registrar	Certificate of De	eath	Reg. No.	29575
Physicia	an/	1. Decedent's Name (First, Middle, Last)		2. Date of De Month	. Day Year	3. Time of Death
Medi	cal	4a. Facility Name (if not institution, give street and number)	4h O'ty Tourn and	septime of Death	122/7,50/0	7 - 7 5/-W
Examir	ner	With with Hospital	4b. City, Town, or Le	dallstown	4c. County of Death	(-1)
Funeral		5. Social Security Number 6. Sex7. Age (In yrs. last to		If Under 24 Hrs. 8, Date of Bir	th 9. Birthplac	ce (State or Foreign
Director		219-30-5007 ** XM 2 = F 81	Yrs. Months Days	Hours Min. $0^{(Month)}_{2-1}$	y, Year) Country)	MD
nd now	_	Usual Residence of Decedent 10a. State 10b. County 10c. City. To	own or Location		10d	. Inside City Limits
arylar sa-f sl	ect		timore		1	1 ☑ Yes 2 ☐ No
or 28	흐	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country	?
s 23a rust b	Funeral Director	1804 Appleton Street	21217	,	USA	
death item ner m	Ē	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.)	14. Race - American Black, White, etc.	African
UUSO Urs after tural", or al Exami	dby	1 Never Married 2 Married 1 X Yes 2 No If Yes, Give Vear or Dates	1 ☐ Yes 2 No	Specify:	Specify: Ameri	
hours hours	Be Completed	15. Decedent's Education	16a. Decedent's Usual Occupati	ion	16b. Kind of Business Indus	
in 72 e. Med	를	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give kind of work done dur life. DO NOT use retired)	ring most of working		
d with ygien ber th	ပို	12th Grade NA (Care Taker		State of M	aryland
yland d be filed Mental Hy arked ott	인 B	17. Father's Name (First, Middle, Last) Harry L. Johnson		18. Mother's Name <i>(First, Middle,</i> Cora M. Co	Maiden Surname)	
Irylig buld b d Mer mark matic						
Mith an ulth an 27 is		Carolyn L. Johnson-Wife	,	d Number or Rural Route Numbe con Street Ba		•
1 and		20a. Method of Disposition 20b. Place	e of Disposition (Name of	Date	20c. Location - City or Town	n, State
dillillor rmit. Page 1 partment of portant: If if y injury or o		1X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gari	rtery, crematory or other place) rison forest	09-27-10	Owings Mill	s, MD
Deficient Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		of Facility Wylie Fu		
		dunda Jones		1mor Street		
		23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only on-cause on each line. Immediate Cause (Final	to not enter the mode of dying,	such as cardiac or respiratory ar	In	pproximate Iterval Between Inset and Death
Physician/ Medical	8	disease or condition resulting in death)	ic			TIOUT GITG DOGITI
Examiner		Due to for as a consequence	se oi).			
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ce of):			
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ate be executed ohysician and the burial-transit	dical E	resulting in death) Last Due to (or as a consequence	se oi):			
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certification ce	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery	
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t the	Phy	g Unknown Part II. Other significant conditions contributing to death but not resulting	ng in the underlying eques sive	n in Bort i	obacco use contribute to the c	
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in: Th ifficate or, pa		25. Was case referred to medical	26. Plac	e of Death (Check only one)	2 No 1 ☐ Yes 2	No
ysicia ysicia is cert	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/	Other		dence 6 Other (Specify)	
ng Pr fter th		27. Manner of Death 1 X Natural 5 Pending 28a. Date of injury (Month, Day, Year)	b. Time of 28c. Injury a work?	at 28d. Describe l	now injury occurred	
ttendi death. tor: A the fu	Certificate:	2 Accident Investigation		es 2 No		
lor At after of Direction by		4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	, farm, street, factory, office	28f. Location (City or Tov	Street and Number or Rural Ro vn, State)	oute Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledg				
the Ho lin 24 the Fu	Med	(Check only one) 3 Certifying Nurse Practioner: To the best of my known				
To t To t		29b. Signature and title of certifier	29c. License n	number	29d. Date signed (Month, Day	/, Year)
14.		Africa Hick	1/445	1/4	Septeber !	7, 20/0
5		30. Name and address of person who completed cause of death (Item 23:	a) (Type, Print)	5.1 P. 1.11.	1	ni la: 1
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1/01/11/2	41 . 149 296, 113	rum mer	- prohot
Registra		SEP 2 2 2010 August 1. 1	barker			,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 20 Physician/ Mary Angela Jirout 2010 6:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2236 Southorn Road Middle River 8. Date of Birth
(Month, Day, Year)
1 18,1921 Baltimore Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Months Hours Director 219-01-7750 89 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD Middle River 1 🗌 Yes 2 🔀 No 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 2236 Southorn Road 21220 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Force þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🕅 No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) At Hame Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Haroldo Prinn, Sr. Myrtle Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2236 Southorn Road, Middle River, MD 21220 Katherine Lacy/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State
 Donation 5 ☐ Other (Specify) oaklawn Cemetery Sept. 24, Baltimore, MD Signature of Funeral Service License 22. Name and Address of Facility
Evans Funeral
8800 Harford Chapel & Cremation Services Road Parkville, MD 21234 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I mediate Cause (Final Ph_sician/ Medical resulting in death) Dificile Colitis Examiner yeur Sequentially list conditions. Examiner if any, leading to Immedia cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🕱 No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown signed by the a 1 Yes 2 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe After this certificate has funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending ☐ Accident Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide mpleted filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Plactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

within 2 To the F

Registrar

only one)

1 4500

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Sign

602

1) 52876

29d. Date signed (Month, Day, Year)

Belair Road Baltimon MD 21236

Please Type of Pint in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physiciar		Decedent's Name (First, Midd	dle,Last)					Month	of Death	ıv Year	3. Time of Death
ledical Examin		LINDA M. JAMES						Sept	ember 1	9, 2010	1548 hrs
è	1	4a. Facility Name (if not institution		er)	4	b. City, Town, or	Location of C	Death		4c. County of Deat Anne Arunde	
*		2054 Knollview Road				Pasadena	Tre tre to a	411 la D-4	f Di-th (t	MM/DD/YYYY) 9. Bi	
Funeral Director	- 1	5. Social Security Number	6. Sex 7.	Age (In yrs. las	st birthday)	If Under 1 Year Months Day		Min		Forei	gn
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ž.	-	Usual Residence of Decedent 10a. State 10b. County	,	10c. City. T	Town or Location	on					10d. Inside City Limits
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15-0 filed Il Hyg ed oth	ωl	17. Father's Name (First, Middle	·					,			
ID 21215-00; should be filed withing and Mental Hygiene in smarked other it matic event, the Mec	որ [ROSCOE WESLEY REN 19a. Informant's Name/Relation			19b. Mailing	Address (Stree	JUANIT et and Numbe	A DOLORE or or Rural Rou	te Number	<u>r, City or Town, Stat</u>	e, Zip Code)
MD 21215-0036 td 2 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f shamarite event, the Medical Examiner must be notified at once	-	LARRY STEVEN JAME		ON	1	ARTIE KEI					
- P = E E	Ì	20a. Method of Disposition		20b. P		tion (Name of ce		Date		0c. Location - City o	r Town, State
MOF Pages nent of ant: If or other		1 Burial 2 XX Crematic		State	1	MATORY IN	c.	SEP. 21	2010	BALTIMO	ORE. MD
Baltimore, permit. Pages I ar Department of Hec Important: If the injury or other tr	t	4 Dopation 5 Other 5 21. S' -t r of Funeral S rvice	e ic nsee	<u>J</u>	22. N	ame and Addres	s of Facility		,		= -
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/Medical Examiner		Immediate Ca Final issas	se 🗽 Hypertensive	Atheroscle	erotic Cardio	ovascular Di	sease				Death
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68760, certificate be nding physici se as the buri		23b. Was decedent pregnant in past 12 months?	the 1 Live birtl	h	2 Fet	tal death 3	Ectopic p	regnancy		Month	Day Year
Box 687 e death certifing the attending	Physician	1 Yes 2 No 9 V		it at time of dea	oth 5 Oth	ner (Specify)			- 5		
the de	휜	Part II. Other significant cond			sulting in the u	nderlying cause	given in Part	1, 23	e. Did toba	cco use contribute t	o the cause of death?
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Divipital or ours after Dir filled in	Certification:		termined (Specify)					or	Town, Stat	e) 	
8 - 2 > 1	- 1	29a. Certifier (Check only 1 Certifying	Physician: To the best of	of my knowledg	ge, death occur	red at the time, o	date and place	e, and due to t	he cause(s	s) and manner as st	ated.
To the Hos within 24 h	Medical		caminer:On the basis of and manner sta	examination ar ted	nd/or investigat			irred at the tim			
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			ranelf M	→		0.0	.M.E.			September 20,	
2	ſ	30. N me and address of personal Melissa Brassell, MD			_	enn Street,	Baltimore	MD 21201			
<u> </u>		31. Date filed (Month, Day, Year		istrar's Signatu				2 120			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Eacility Name (if not institution, give street and number, 4b. Cjtg, Town, or Location of Death 4c. County of Death Examiner 9. Birthplace (State or Foreign If Under 24 Hrs 8. Date of Birth 5. Social Security Number **Funeral** Min. Months Hours 1 🕱 M 2 🗆 F 0370471934 N.Carolina 237-46-6388 76 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 Xyes 2 No MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or items 23a Funeral 4010 Gelston Dr. <u> 21</u>229 S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: If Yes Give "natural", Completed 3 Widowed 4X Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 's niury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event, the Meany once. College (1-4 or 5+) Elementary/Seconday (0-12) 12th Grade Bethlehem Steel <u>St</u>eel worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Wesley Knox Georgianna unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley McClellan(daughter 1626 Clifton Ave., Baltimore, MD 21213 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Baltimore Nat'L 09/21/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD ²Joseph Address of Fallyown Jr. Funeral Home PA 2140 N Fulton Ave., Baltimore, MD 21217 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eum on a Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) Pregnant at time of death 2 No 1 L Yes 2 L g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has page 2 s performed' 1 Yes 2 No Yes 2 25. Was case referred to medica examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, Be Hospital: 1 ☐ Yes 2 ₩ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, seam occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sighat 8928 person who completed cause of death (Item 23a) (Type, Print) North 3/10

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER 18 2010 MARY KRATZEN 1928 hrs Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CENTER TOWSON BALTIMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 🛛 F Min. 86 027 PENNSYLVANIA **Director** 196 18 1530 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD BALTIMORE ROSEDALE 1 🗆 Yes 2 🔀 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 1324 PINE GROVE AVE 21237 USA items 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc "natural", or 1 Never Married 2 Married Completed by 1 ☐ Yes 2 XNo If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Year or Dates the M dical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) SALE ASSOCIATE DEPARTMENT STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 MICHAEL POPELISH ANNA MOROSKO 19a. Informant's Name/Relationship (Type, Print) DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY FRANCES BRECKER LOCUST LANE SYKESVILLE, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State GARDENS OF FAITH 19/21/10 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Fundant Scripte Licensee 22. Name and Address of FacilityCVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, juch as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequ Examiner ears Gequentiany fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown P.0. s been signed k should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, To the Hospital or Attending Physician: The law requires 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Yes 2 1 Yes 2 🗌 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Spe Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar filed (Month, Day, Year)

SEP 2 2 2010

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6701

who completed cause of death (Item 23a) (Type, Print)

32. Registraris Signature

DHMH 17 Rev 1/2001

Bruce Owen Katzenberger

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 0 2968 |

		- For State		Cert	ificate of	Death			Reg.	. No.		
Physicia		egistrar I. Decedent's Name (First, Middl	e,Last)						ate of Death	Day Year	3. Time of Death	
filysicia ^ √ical Examir		Bruce Owen		erger				Se	ptember	17, 2010	1120 hrs]
7	_	4a. Facility Name (if not institution			41	o. City, Town, or L	ocation of			4c. County of	f Death	
		202 Preston Court				Catonsville				Baltimore	County	
			6. Sex 7. A	Age (in yrs. las	st birthday)	if Under 1 Year	If Under	24Hrs. 8. f	Date of Birth	(MM/DD/YYYY)	9. Birthplace (State or	\neg
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Maryland 28a-f show d at once.	용ト	10e. Street and Number				10f. Zip Code			10g	g. Citizen of Wha	at Country?	
with the Maryland ns 23a or 28a-f sho be notified at once.	Director			D		21228				TT	S.A.	
th th 23a notif		202 Preston Co	ourt Apt 12. Was Decede		13 Was	Decedent of Hisp		n? (Specify	Yes or No-		- American Indian, Black,	
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121 Id be fil Mental I narked event,	B	William Ka	tzenberger.	Sr.			Je:	nnie	S	hupe	e State Zin Code\	\dashv
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ti Pa		4 Donation 5 Other S 21. Signature of Funeral Service	pecify:	T AL	22. N	ame and Address	of Facility					MT.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	ı į	Signature of Fulleral Service	·	2147							len Burnie, rvices, P.A.	תוז
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Physician		failure. List only one cause	on each line.					- 11			Between Onset : Death	and
/Medical /Examiner		Immediate Cause (Final disease				n						
		or condition resulting in death)	Due to (or as a co	nsequence of	r):							
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Division of Vital Records, P.O. Box 68' tall or attending Physician: The law requires that the death certif ars after death. "at Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as	Certification:		uld not be ermined (Specify)	Hous		,		Cat	or Town S	lle, MD	per or Rural Route Number, Preston Cour	C
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Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page		Torrect oray	Physician: To the best of arminer: On the basis of	of my knowled	lge, death occur and/or investigat	red at the time, da tion, in my opinion	ate and pla n, death oca	ice, and due curred at the	e to me caus a time, date a	e(s) and marine and place, and (due to the cause(s)	
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2	ž	29b. Signature and title of certif	ner).			29c. Licens						
(2)		Mousente	he Shill	_		O.C.	M.E.			Septembe	10, 2010	
(3)		30. Name and address of person	on who completed cause	of death (Item	n 23a)			····				
	10. 3	Margarita Korell MD.	Assistant Medic	cal Examir	ner 111 P	enn Street, B	altimore	e, MD 212	201			
	tate	31. Date filed (Month, Day, Yea	7) 32. Regi	strar's signat	perker							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sept 17, 2010 Ann Madeline Lipscomb 5:06 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Hanover 7657 Clark Rd. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XX Months Days Hours Min (Month, Day, Year MAY 25, 577-94-6652 48 1962 Washington, DC **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits notified at 10c, City, Town or Location Director 1 Yes 2XX No MD Anne Arundel Hanover 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? the Medical Examiner must be Funeral 23a 7657 Clark Rd 21076 USA items permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XXNo Black. White, etc. 1XX Never Married 2 Married Completed by Baltimore. Maryland 21215-0036 1 XXYes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Richard Lipscomb Gertrude Sheran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessica Simones Seyfried 11003 Horseshoe Dr., Frederick, MD 21701-3357 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview\Crematory Sept 18, 2010 Baltimore, MD Name and Address of Facility
Fink Funeral Home, P.A. ink M01148 426 Crain Hwy. Gregory South, Glen Burnie, MD 21061 nter the disease heart fature. Li mp cations that caused the death. Do not enter the mode of lying, such as cardiac or respiratory arres Approximate Interval Between Onset and Death 23a. Part 1 or d Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and inding physician ause as the burial-Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy certificate No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4
Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending Natural 2 🗆 No Accident 1 Yes Investigation after deat Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiney: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie within 24 ho

To the Fune (Check Certifying-Nurse (Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signe (Month, Day)

State Registrar

31. Date filed (Month, Day

DHMH 17 Rev 7/2009

(Type, Print)

cause of death (Item 23a)

32. Registrar's Signature

who completed

			AMEND 2	Please 28D, PER	Type or Property of No.	int in 1 /8/12 /arylan	Black Ir d / Depa	ndelible Inlartment of F	k. Ensure lealth and	All Copie Mental Hy	s Are Le g	gible.	
			State Registrar					tificate of L			Reg. No.	10	29683
	Physicia Medic		1. Decedent's Nam	ne (First, Middle, Las RT LEE	LAYFIEL	D				2. Date of De	BER Day 7	20 ⁴ f%	3. Time of Death 7:58 a.m
	Examir		4a. Facility Name (iii GOLDEN	f not institution, give	street and number)			4b. City, Town, or FREDER		h		y of Death	
	Funeral Director		5. Social Security N 217 09		ex 7. A	ge (In <i>yr</i> s. Ia 92	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.				place (State <i>or Foreig</i> n RYLAND
	nd now	Ļ	Usual Residence of 10a. State	Decedent 10b, County	-	10c. City	. Town or Loc	eation					10d. Inside City Limits
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21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with injury or other traumatic event, the Medical Examiner must be neitified at once.	ρ	11. Marital Status 1 ☐ Never Mari 3 ເXWidowed	ried 2 Married	12. Was Decedent Armed Forces 1 X Yes 2 If Yes, Give Year or Dates	? DNo	1	Vas Decedent of H Yes, specify Cuba		pecify yes or No- to Rican, etc.)		ce - Ameri ck, White, /: WHI	
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	and 2 sh Health ar tem 27 is			NETH E.			1	CLOIST					
Baltimore,	ge 1 ar t of He If item or oth		20a. Method of Dis 1 Burial 2	position Cremation 3	Removal from Stat			sition (Name of natory or other place	e)	Date	20c. Location	-	
Itim	permit. Page 'Department o'Important: If any injury or once,		-	5 X Other (Special		r GAF		OF FAIT		21/10	BALTI		, MD ERAL HOME
Ba	permi Depar Impo any ir) Signature of The						SACO A				21237
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. Box (or Attending Physicians: The law requires that the death certificate be after dark. Jifferdor, Affer this certificate has been signed by the attending physic in by the funeral director, page 2 should be detached for use as the br	Physician/Medical	23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?		at time of d	Ideath 3 🗌	Ectopic pregnand Other (specify)	ey			ate of deli	very Day Year
P.O.	that the	by P		ficant conditions o	ontributing to death	but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use cor	tribute to	the cause of death?
Records,	v requires the been signal should be	eted		ent ov							Yes 2 No		bbably 4 Unknown
eco	has b	Completed	Hype	v densi			1			24a. Was auto perf	psy	prior to codeath?	opsy findings available ompletion of cause of
E E	sician; The la certificate ha rector, page	Be Co	25. Was case referr	red to medical	o Kei	na/	191	147A 26. PI	ace of Death (Che		ormed? 2 No	1 🗌 Yes	2 No
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n of	ding P h. After ti funera	ate:	27. Manner of Deat	5 Pending	28a. Date of in (Month, D	ay, Year)	28b. Time of injury	28c. Injury		28d. Describe	how injury occur		nom TIVI I
Division	Atten	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not be determined	e 28e. lace of Ir	njury - At ho	MOKNO me, farm, stre	et, factory, office	165 2 2 100				ECT FELL al Route Number,
DΪ	ital or ars afte ral Dir lled in				Devot	tc. (Specify,		sted U	Ving pl	City or To	wn, State)	n'c k	mo.
	Hosp 24 hou Fune eted fil	Medical	(Check 2	Certifying Phy Medical Exam Certifying Nur	iner: On the basis of	examination	and/or invest	igation, in my opinio	on, death occurred	at the time, date	and place, and d	ue to the c	ause(s) and manner stated.
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director, After th completed filled in by the funeral	2		tle of certifier	Se Plactioner. 10 th	e best of my	Kilowiedge, c	29c. License		lace, and due to t	29d. Date sign		
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	13,		30. Name and addr	ress of person who			1	rint)	51643	04. 0	nn e	2,21	13
	Star Registra		31. Date SEP 2	750 m s th, Day, Year) 2 2010		trar's Signat		<i>g</i>	* UCN		<i>U</i> • <i>V</i>	1.7	

			_ State	ate of Maryla	-	artment of He tificate of D			0010	00501
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	incate of D	Catri	2. Date of Death	g. No.?	3. Time of Death
	Physicia Medic		DR. ELENORA LEI	E-HARGROVE				Month Septembe	r 15 2010	11:134
	Examin		4a. Facility Name (if not institution, give street a	nd number)		4b. City, Town, or I			4c. County of Deat	h
			4310 BREHMS LANE			BALTI			N/A	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs.	last birthday) 56 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y AUG 2	rear) 54 MAR	thplace (State or Foreign untry) XYLAND
	and show I at	5	Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Loc	cation				10d. Inside City Limits
	Maryl 28a-f otifiec	Director	MARYLAND N/A			BALTIMO	RE			1X Yes 2 □ No
	h the	alD	10e. Street and Number			10f. Zip Code		10	g, Citizen of What Co	untry?
	ms 2 must	Funeral	4310 BREHMS LANE	us Decedent Ever in U	I	21206 Vas Decedent of His		cify Yes or No-	U.S.A.	rican Indian
ယ္	er dea or ite	by Fi	11. Marital Status 12. Warried 2 Married 1 1. Never Married 2 Married 1 1.	med Forces? Yes 2 XXNo	l I	f Yes, specify Cuban	, Mexican, Puerto	Rican, etc.)	Black, White	
933	ırs aft ural", IExa	ted	o Davids at AVV	'es, Give ar or Dates.	1	☐ Yes 2XXXNo	Specify:		Specify: BI	ACK
5-(72 hou "nat	Completed	15. Decedent's Education (Specify only highest grade com	n pleted)	(Give I	lent's Usual Occupa kind of work done du		ing 1	6b. Kind of Business	Industry
21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygene. is marked other than "natural", or items 23a or 28a-f sho is marked other than "natural", or items 25a or 28a-f sho aumatic event, the Madical Examiner must be notified at		Elementary/Seconday (0-12) Co	llege (1-4 or 5+) 6yrs		O NOT use retired) OLOGIST	_		HEALTH F	EDUCATION
pu	be filed vental Hygred ked other ic event,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Ma	aiden Surname)	
Maryland	should be file and Mental I is marked o raumatic eve	욘	JOHN LEE					WILSON		
Ma	2 sho tth and 27 is r traur		19a. Informant's Name/Relationship (Type, Prin Ashley Hargrove/Daug	,					City or Town, State, Zip aryland 21	
<u>ē</u>	1 and if Hea item other		20a. Method of Disposition	20b	Place of Dispo	sition (Name of			20c. Location - City or	
<u>m</u>	Page nent c ant: If		1XXXBurial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)			natory or other place IORIAL PAR		3-10	BALTIMORE,	MARYLAND
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign ure of Funeral Service Licensee	_	W	Name and Address VILLIAM C 206 W NOR	of Facility BROWN CO	MMUNITY F	FUNERAL HO	DME P.A.
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus	that caused the de					ıt,	Approximate
	nysician/		Immediate Cause (Final disease or condition	MER	STICE OF	CD	1200	- CA		Onset and Death
-	Medical Examiner		resulting in death)	Due to (or as a conse	quence of):					+ 7/2
		ner	Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying	Due to (or es é come	quence off					V
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	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a conse	quence of):					
200	cate b physi s the b	ledical	d							
89 >	aath certific attending I for use as	an/N	ZSD, Was decedent pregnant	ves, outcome of preg		Ectopic pregnancy	,		23d. Date of de	,
Box	the Hospital or Attending Physician: The law requires that the death certificate be executed that 4 hours and effect death. The Huneral Diffector, the this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	1 Ves 2 No 4	Pregnant at time o Unknown		Other (specify)			Month	Day Year
P.O.	that the ned by e detac	by Pr	Part II. Other significant conditions contribut	ng to death but not r	esulting in the u	inderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ds,	requires t been sign should be	ted						1 🗌 Yes	s 2 2 No 3 □ P	robably 4 🗌 Unknown
Records,	has be	Completed						24a. Was an autopsy perform	prior to death?	stopsy findings available completion of cause of
Ä	sician: The law s certificate has t lirector, page 2 s		25. Was case referred to medical			26. Pla	ce of Death (Checi	1 ☐ Yes 2	No 1 ☐ Ye	s 2 □ ₩6
of Vital	nysicia iis cert direct	To Be	examiner? 1 ☐ Yes 2 ☐ No Hospita	l: 1	☐ ER/Outpatier	Othor	r.		nce 6 Other (Spec	cify)
οl	ding Ph h. After th funeral		1 Natural 5 ☐ Pending	a. Date of injury (Month, Day, Year)	28b. Time of injury	work?		28d. Describe hov	v injury occurred	
Division	I or Attendii after death. Director: Ai I in by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	e. Place of Injury - At			res 2 🗆 No		eet and Number or Ru	ural Route Number,
Divi	tal or A rs after al Direct ed in by		4 - Hornicide determined	building, etc. (Spec	ify)			City or Town,	State)	/.
	To the Hospital of within 24 hours a To the Funeral D completed filled it	Medical	29a. Certifier 1 Certifying Physician: 2 Medical Examiner: On	the basis of examinat	ion and/or invest	tigation, in my opinior	n, death occurred a	t the time, date and	place, and due to the	cause(s) and manner stated.
	To the within To the Comple	Σ	only one) 3 Certifying Nurse Prac 29b. Signature and title of certifier	To the best of	my knowledge, c	2°c. License			Date signed (Mont	
			Buroku	Ur PV	D	17.2	1398	.	1-21-	10
3			30. Name and address of person who complet	ed cause of death (Ite	em 23a) (Type, F	s Dr Se	340 D	vince Mi	16, MD 2	1117
	Stat Registra		31. Date filed (Month, Day, Year) SEP 2 2 2010	32. Registrar's Sign	iature Land	1			16, MD 2	

DHMH 17 Rev 7/2009

George Lewis 10-07217 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ 0742 hrs September 19, 2010 Lewis Medical Examine George 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital Baltimore 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Min. Months Days Hours 9-3-1985 MD 213-11-6423 25 Director Country) 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location any 1 X Yes 2 No MD Baltimore other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. na hours after death with the Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1110 Somerset Street 21202 USA 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes Specify: Black 1 Yes 2 No specify: 4 Divorced If Yes, Give Year ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade College (1-4 or 5+) filed within 72 Unemployed permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other th injury or other traumatic event, the Medi 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last item 27 is marked traumatic event, Darnella Carter George G. Lewis, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Lewis-Uncle 5900 Frankford Avenue Balto, MD 21206 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 9-25-2010 Randallstown, MD King Memorial Pk Donation 5 Other Specify 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licenses Balto, MD 1101 E.North Avenue nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Michigan Death a. Gunshot Wounds (2) of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o <u>გ</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown σ. Completed Records, has been s 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? certificate h 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical of Vital Be examiner? Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes 2 No 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 27. Manner of Death Certification: Sep 19, 2010 Subject shot Natural 0443 hrs Division 1 Yes 2 ✔ No 5 Pending death. Director: Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. hours after 3 Suicide Could not be or Town, State) 1200 Block of Bonaparte Avenue , Baltimore , MD determined To the Funeral I (Specify) Local Street 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 / Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 19, 2010 O.C.M.E. n 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Donna M. Vincenti, MD 111 Penn Street, Baltimore, MD 21201 31. Date filed WETP, Day 2 2010 Registrar's Signa State Registrar

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			State of Maryland / Departr 1- State Amend Items 24a,25,26,27 per Certifi	ment of Health and M 2907, 0972272010 Cate of Death	lental Hygier	1e 4010 29687
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
	/Medic		Mona Rose Musgrave			Pay 2010 9:30 PM
	Examin	ier		City, Town, or Location of Death Silver Spring	'	4c. County of Death Montgomery
	Funeral			Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birtholace (State or Foreign
	Director		235-50-6716 1 M 2 F 75 Yrs. M	onths Days Hours Min.	May 25, 1	935 West Virginia
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	20		10d. Inside City Limits
	Aaryla f sho	ō	MD Montgomery Silver Sp			1 ☐ Yes 2√∑No
	28a-	Director		Of. Zip Code	10g.	Citizen of What Country?
	d within 72 hours after death with the Maryland jiene. r then "naturel", or tems 23e or 28e-f show the Marical Examinational the notified at		14000 Castle Blvd #307	20904		USA
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces?	Decedent of Hispanic Origin? (Spe s, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	or It	by Fu	1 Never Married 2 Married 1 Yes 2 No	Yes 2⊠ No Specify:	,	Specify: White
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212	filed within I Hygiene. other then "	Completed		etary		Weapons Center
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<u></u>	should be and Mental marked o	은	George Arnold Musgrave		Esther Co	
Maryland 21215-0036	07			ddress (Street and Number or Rura Millstone Court		ty or Town, State, Zip Code) t City, MD 21043
	is 1 and 2 of Health a item 27 is other tree		20a. Method of Disposition 20b. Place of Disposition		Date 20c	. Location - City or Town, State
Baltimore,			1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State *4 ☑ Donation 5 ☐ Other (Specify)	ry or other place)		
altii	permit. Page Department Importent: If any Injury or once.		4 1	ame and Address of Facility Sta	te Anatom	y Board
Ω	9 9 2 2 3		Committee and additional of the control of the cont	55 W. Baltimore	Street; B	altimore, MD 21201
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock or heart failure. List only one cause on each line.	ne mode of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	RE3PINATORY 1	MY WIE	Citset and Death
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		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~ NJOFF		
	te be executed ysician and e burial-transit	Examlne	cause. Enter Underlying Cause (Disease or injury that initiated events	NEWSIVE HE IPL FIBRIL	ANT 018	EB8E-
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ls, P.	requires that the reen signed by th hould be detache	by Pi	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
rd	w require been sig should b				1 🗌 Yes	2 No 3 Probably 4 Unknown
ecc	aw 2 s	ompleted			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Vital Record	Th ate pag	Cou			performed 1 ☐ Yes 2 🖸	!? death? No 1 ☐ Yes 2 ☐ No
Vita	Physicien: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?		h (Check only one)	
of	Phys rthis ral di	. To	1 Tes 2 12 No 1 Inpatient 2 ER/Outpatient 3	3 DOA 44 Nursing Ho	me 5 Residence	e 6 Other (Specify)
lon	Attending I r death. ector: After by the funer	tlor	1 X Natural 5 Pending (Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		,,
Division	or Attendii after death. Director: A d in by the fu	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number,
Ö	spitel or At ours after c serel Direc filled in by		building, etc. (Specify)		City of Town, 3	1010)
	Hos Fur Tely	ledical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death oc (Check only one) 1 Medical Examiner: On the basis of examination and/or invest and manner stated.	curred at the time, date and place, igation, in my opinion, death occurr	and due to the caus red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complete	ž	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
•			, Chilma D	1263232		TIMINI
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin PTMY) 6 (20 MP), MO: 15MS 5HAD1	1063232 Gro4 Mo. Mich	viWE.	ms x820
	Sta	ite	31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	7100 0 1001		
	Registi		31. Date filed (Month, Day, Year) SEP 2 2 2010 SEP 3. Jean S. Jean S. Jean	Kal		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 17 415 A M Physician/ George Adam John Maex 50nramson DUID Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Good Samaritan Hospital . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Mar. 12, 1933 Maryland 212-30-6961 1 🙀 M 2 🗆 Director Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits the Medical Examiner must be notified at Director Parkville Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be Funeral 8805 Richmond Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 √ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 Specify: white 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Locke Insulator Planner Estimator 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Starklauf George Maex, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 8805 Richmond Avenue-Parkville, Maryland Lillian Maex-spouse 20b. Place of Disposition (Name of cemetery, crematory or office place)

Evans Funeral Chapel and Cremation Belair 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sept. 22, 2010 Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans. Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final enysician/ Signsis Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Gause (Disease of impury that initiated events Due to (or as a consequence of): use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Month Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires th within 24 hours after death.

To the Funeral Director: After this certificate has been signs completed filled in by the funeral director, page 2 should be DUANETES MELLINIS No 3 Probably 4 Unknown Completed MENVINNA VOSLULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an OSTENAYELITIS autopsy performe REMM WSNEPICIONLY 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number

State Registrar

MX

MASY, GETURO

park

32. Registrar's Signature

SLUI WILL ROWN SUD SATIMAN, MD 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PEMALURE P. SWIT MID

SEP 2 2 2010

31. Date filed (Month, Day, Year)

SENTEMSON IX, 2014

10-07148 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Lindsey Marie Madore 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Lindsey Marie Madore 1810 hrs **Medical Examiner** September 16, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 833 Bridle Path Harford 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 6. Sex **Funeral** oreign Maryland Days Months Hours Jan. 13, 1982 212-19-8907 28 Director 1 M 2 F Usual Residence of Deceden any 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2XX No 28a-f show Director Maryland Bel Harford Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21014 833 Bridle Path Funeral 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2 X No 1 Yes 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Medical Office Medical Biller 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last George F. Madore Judith Hammilton Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Capitano / Mother 833 Bridle Path Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State Evans Funeral Chapel Forest Hill, Maryland 4 Dopption 5 Other Specify: re of Fungral Service License 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services—BelAi 13 Newport Drive Forest Hill, Maryland plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or com **Physician** Between Onset and failure, List only one cause on each line Medical Morphine and diazepam intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last hysician/Medical AMENDED 28d, per ME G984 2/27/14 TRC 23a, PII, 27, 28a-f, per ME g908 10.21.10 TT physician a X UNPENDED The law requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the Day Live birth 3 Ectopic pregnancy Month Year 2 Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? 靣 contributing to death but not resulting in the underlying cause given in Part I. o. ş ۵. 1 Yes 2 No 3 Probably 4 V Unknown Cocaine use Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed ✓ Yes 2 No 2 No certificate 1 🗸 Yes 26. Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene After this 1 V Yes 2 No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27, Manner of Death Certification: 1 Natural 1 Yes 2 XNo 41n k Director: Pending after death. Fd 1755 hrs Fd 9/16/10 subject took drugs 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 833 Bridle Path Bel Air, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 Could not be residence determined (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. September 17, 2010 and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date fil SEPth 2 2 2010 32. Registrar's Signature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 15 Month 9 Physician/ G:04PM Morden Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Beltmore n/a University of Maryland Madreal (-+ If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Michigan 1 XX M 2 □ F 386-34-3366 1936 73 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🗶 No Marvland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21093 1323 Malbay Dr. United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2

If Yes, Give Black, White, etc. 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced Year or Dates. 1969-77 white 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Vice Pres/Gen Mgr of Operations | US Govt/Army Logistics 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clare Morden Lucille McLeod 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lutherville, MD 1323 Malbay Dr. Emel Morden/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XX Cremation 3 Removal from State Green Mount Crematory |Sep. 17,2010| Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) John O. Mitchell IV, Funeral Services of Dulaney Vally 200 E. Padonia Rd. Timonium, MD 21093 P.A. 21. Signature of Funeral Service Licensee part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Homerchaice Physician cerel disease or condition resulting in death) ZVZ Medical Due to (or as a consequence of) Examiner 110516 Sequentially list conditions Examiner if the Levil is to immedicause. Enter Underlying as a consequence of attending physician and for use as the burial-transit Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🔀 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? ဂ္ 1 🗌 Yes 2 X No 1X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work?
1
Yes Certificate: 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending injury 2 🗌 No Accident Investigation Suicide 8 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 15-10 M.D. AU4176435B198*9*9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 22 Greene 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Newton Physician/ Scott Man 1852 M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** CARROLL CARROLL HOSPITAL CENTER WESTMINSTER 9. Birthplace (State or Foreign If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country)
JASHINGTON, OC 1 🛛 M 2 🗆 F 217828353 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🙇 No mio SYKESVILLE 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral USA 6420 21784 H166 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' Black White etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) II THER Be 18, Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ပ NEWTON RAYMOND MORRIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6420 CAKHILL DRIVE SYKESVILLE MO NEWTON WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 🗔 Removal from State 9/22/2010 SYKESVILLE AKEVIEW MEM PK 4 Donation 5 Other (Specify) 22. Name and Address of Facility \ NZUMRWN FIT & mov CO Signature of Funeral Service Licensee 6028 SYKESVILLE RD ELDERSBURG-MO 21784 23a. Reft 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a conse y ence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 1 Yes 2 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate has death? performed' 1 ☐ Yes 2 ☐ No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examine?
1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check and address of person who completed cause of death (Item 23a) (Type, Print) East Main cheet Westwinster MO MINT 31. Date flied (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 4:30 AM NOPPER 09 2010 N 8 MARIE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HOSPITAL BALTIMORE BALTIMORE GOOD SAMARTTAN If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, January 5. Social Security Number 7. Age (In yrs. last birthday) Days Maryland 215-05-6262 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2X No Towson Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21286 38 Acorn Cir. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 X No Specify: Specify: white 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ella Sheldon George Nazarenus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3200 E. Oakwood Rd. Oxford, MI Kimberly Nagle/daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem GardSep. 20,2010 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212 John Witchell

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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Department of Health and Mental Hygiens (Input) activates are useful with the Malyla Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Malical Expriner must be notified at once.

Pages 1 and 2 should be filed within 72 hours after

Saltimore, Maryland 21215-0036

death with the Maryland

/Medical

10a State

To the Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-tran the cate has been signed by page 2 should be detach 24 hours after death. Funeral Director; A completely filled in by the within 2

Division of Vital Records, P.O. Box 68760,

	70/10/ 1/10/00/00	70 020	O LOLIC ICC. DOLL	V	
	23a. Par 1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death. Do not enter ne cause on each line.	the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition	CARDIOMYOPATI	+γ		7 DAYS
	resulting in death)	Due to (or as a consequence of):	53		1
	Sequentially list conditions.	PULMONARY H	YPERTENSION		
ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of).			
ami	Cause (Disease or injury that initiated events				
Ä	resulting in death) Last	Due to (or as a consequence of):			
ical		1			
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		Ectopic pregnancy Other (specify)	23d. Date Mont	of delivery h Day Year
문	Part II. Other significant conditions cor	ntributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did tobacco use contrib	oute to the cause of death?
d b	DIABETES MELL			1 Yes 2 No 3	B□ Probably 4⊠ Unknown
etec		, , , , , , , , , , , , , , , , , , , ,		24a. Was an 24b. W	ere autopsy findings available
ם	CHF			autopsy pr performed? de	ior to completion of cause of eath?
	HYPERTENSION			1 ☐ Yes 2 🗷 No 1	Tyes 2□No
Be	25. Was case referred to medical examiner?	Hospital:	Other:	ath (Check only one)	
မ	ILI fes ZIZINO	1 ☑ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury 28b. Time of	3 DOA 4 I Nursing F	forme 5 ☐ Residence 6 ☐ Other 28d. Describe how injury occurred	
ion:	27. Manner of Death 1 Natural 5 ☐ Pending	(Month, Day, Year)	28c. Injury at Work? M 1 □ Yes 2 □ No	20d. Describe flow injury occurred	u
cat	2 Accident investigation 3 Suicide 6 Could not be			28f. Location (Street and Number	e or Durol Bauta Number
ertifi	4 ☐ Homicide determined	28e. Place of Injury - At home, farm, stree building, etc. (Specify)	n, ractory, ornice	City or Town, State)	or nara noute vumber,
Medical Certification: To	(Check only 2 Medical Exami	slcian: To the best of my knowledge, death iner: On the basis of examination and/or inve	occurred at the time, date and placestigation, in my opinion, death occ	e, and due to the cause(s) and mar urred at the time, date and place, an	nner as stated. nd due to the cause(s)
Med	one)	and manner stated.	29c. License number	29d, Date signed	(Month, Day, Year)

RES 000

09/18/2010

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature S. pares

RESIDENT

PHYSICIAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMEER CHAUDHARI, MD. 5601, LOCH RAVEN BLVD, BALTIMORE, MD -21239

			For Amend Item State Registrar	8 per of Marylan	d 63/02 Cei	ะ ท่าง จา ^t สโป rtificate of L	Health and N Death		giene Reg. No. 2	0 29693
	Physicia	n/	1. Decedent's Name (First, Middle, Last Sylvia Etta					2. Date of Dea		3. Time of Death 1900 M
~~.	Medic Examin		4a. Facility Name (if not institution, give s	street and number)		1	r Location of Death		4c. County of	Death
wee!	, 		Prince George's 5. Social Security Number 6. Sec			C If Under 1 Year	heverly If Under 24 Hrs.	8. Date of Birtl		George's 9. Birthplace (State or Foreign
	Funeral Director		579-84-9326 ^{1[}	☐ M 2 🛂 F 51	Yrs.	Months Days	Hours Min.	05/29/1	9 59 V	vash., DC
	and show sat	or	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
	Maryl 28a-f notifie	Director	MD Prince G	eorge's	0	xon Hil	1		ii .	1 X Yes 2 □ No
	with the 23a or	Funeral D	10e. Street and Number 5212 Leverett	St.		10f. Zip Code	0745		10g. Citizen of Wh	
980	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heath and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at ea.	by	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 1 No	ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. Black
15-0	72 hour "natu ledical	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup	ation during most of work	ing	16b. Kind of Busi	ness Industry
212	within giene. er thar the M		Elementary/Seconday (0-12)	College (1-4 or 5+) 4	ı	o NOT use retired) entory	Special	ist		Oil
and	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) Thomas A. P	roctor			18. Mother's Nam Alic			
aryl	should I and Me is marl raumati		19a. Informant's Name/Relationship (Type	·	19b. Mailir	ng Address (Street	and Number or Run			te, Zip Code)
e,	and 2 s Health s em 27 ther tra		Alice Proctor /			Leveret		1	ill, MD	
mor	Page 1 ment of l tant: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State Co	emetery, crer	natory or other place ction Ce	ce)	Date -2010	20c. Location - C	on, MD
Baltimore, Maryland 21215-0036	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		21. Signature of Funeral Service License		22	2. Name and Addres	ss of Facility ${ m Th}$	e House		iams Funeral Ave, NW 20011
		Š.	23a. Part 1. Enter the disease, or compleshock, or heart failure. List only on	lications that caused the death e cause on each line.	n. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arm	est, × //	Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a ponsequ	lence of	stem	024	en t	all	Onset and Death
	Examiner	_	Sequentially list conditions.	. Je	ste	i of	low	8		
	ted nsit	Examiner	Sequentially list conditions, if a y lead grown cause. Enter Underlying Cause (Disease or linjury	Due to (or en grandige	ence ch:	m	-			
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. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Sc. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	ideath 3	Ectopic pregnand Other (specify)	су		23d. Date Monti	
Division of Vital Records, P.O.	es that the igned by be detaction		Part II. Other significant conditions cor	ntributing to death but not resi	ulting in the u	inderlying cause give	ven in Part I.			ute to the cause of death?
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ita	Physician: The lav r this certificate has aral director, page 2	Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:		Toth	ace of Death (Chec	k only one)	1	
of V	ing Physical distribution	ate: To	27. Magner of Death 1 Natural 5 Pending	1 M. Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injun work	y at		ence 6 Other ow injury occurred	(Specify)
isior	Attend er death ector; A by the f	Certificate:	2(Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho			Yes 2 ☐ No			or Rural Route Number,
<u>`</u>	pital or surs afte eral Dir filled in	Sal		building, etc. (Specify,		I a b b a b		City or Tow		
	ne Hosi in 24 ho ne Fune pleted i	Medical	(Check 2 Medical Examin	cian: To the best of my knowler: On the basis of examination Practioner: To the best of my	and/or invest	tigation, in my opinio	on, death occurred a	t the time, date ar	nd place, and due to	the cause(s) and manner stated.
	To t with To th	_	29b. Signature and title of certifier	2		29c. License		2	29d. Date signed (Month, Day, Year)
			30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, F	Print)	30318		47	110
	- C		Demetrios J. Co	atezenis, M	.D. /	3001 Hc	spital I	or. / Ch	neverly	MD 20785
	Stat Registra		SEP 2 2 2010	32. Registrar's Signat	AJEN					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 08:05 AM SEPTEMBER 11 Frederick Henry Pfeffer 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SAINT JOSEPH MEDICAL CENTER TOWSON Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 03/27/7944 1 🔀 M 2 🗆 F Months Hours Mary land 215-40-2528 66 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location within 72 hours after death with the Maryland Director Baltimore 1XXYes 2 ☐ No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 2516 Hamilton Avenue 21214 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12 Was Decedent Ever in U.S. Armed Forces Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced White Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Stationary Engineer 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ida Elizabeth Williams Frederick William Pfeffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2516 Hamilton Avenue, Baltimore, Maryland 21214 Juanita Pfeffer (Wife) Evelyn 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 ☐ Burial ②CCC Cremation 3 ☐ Removal from State Bayview Crematory 09/27/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Frineral Same License 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 apt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA Pnysician/ sease or condition esulting in death) 5 WEEKS Medical Due to (or as a consequence of Examiner LUNG CANCER EARS NON SMALL Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for sels nonecouches of burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) signed by the and be detached for 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform Yes 2 No 1 Yes 2 No this certificate **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D 46082 pande 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON, MARY LAND OSLER DRIVE S. DESHPANDE, M.D. 7601

DHMH 17 Rev 7/2009

State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Registrar

SFP 2 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** RUBI LEE PERRY September 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1.405 Baltimore N/A of Baltmore pria 6, ty If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Pate of Birth (Month, Day, Year) 2-19-1953 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🖾 F Days Months NEW YORK Director 138-46-4098 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examination stat be notified at 1 XYes 2 No Director N/A BALTIMORE MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 21216 USA 3333 ALTO RD. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2X No Specify: BLACK Specify þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -12-TEACHER AIDE EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental MAGGIE WEST SAUL PERRY SR. ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3333 ALTO RD. BALTIMORE, MARYLAND 21216 SADIKQUAH PERRY (DAUGHTER) permit. Pages 1 and:
Department of Health
Important: If item 27
any Injury or other tr.
once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State MT. ZION CEMETERY 9-25-2010 BALTIMORE, MARYLAND 4 □ Donation 5 □ other (Specify) e of Funeral Se Licensee JONATHXN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Por 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cause on each line. Imm Mate Cause (Final disease or condition resulting in death) **Physician** Acute Mycardial /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 □Yes 2 🖼 🕷 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical exampler?
1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 2010 10054482 September

State Registrar

DHMH 17 Rev 1/2001

Sinai

Hospital of Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

McGinley

M.a.

				For State Registrer		Stat	te of Ma	ryland			nt of Hea te of De		Mental Hy	gien	0 1 0	296	97
		Physici	an	1. Decedent's Name									2. Date of D Month	eath		3. Time (-
		/Medic	·al	Rosalino		Jean give street at	Re	dd		4h Cih	Town or Lo	cation of Deat			c. County of Dea		8 bu
		Examin	er	Coustan		eNV	Wing	and	lehabi	5 5	tion	Balt	more		Balt	mol	
		Funeral Director		5. Social Security N 213-30-1	L585	6. Sex 1 ☐ M 20		(In yrs. Ia 77	st birthday) 7 Yrs.	If Unde Months		Under 24 Hrs Hours Min.		irth a <i>y, Yeal</i> /193		thplace (State ountry) cyland	or Foreign
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	death with the Maryland	la-f eh	Director	MD	Balti	nore		Ess	sex							1 X Ye	s 2 No
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	36 after	or ita	y Fur	1 Never Marri		ed 1 🗆	ed Forces? Yes 2⊠N es, Give	lo				viexican, Puer Specify:	to Hican, etc.)		Black, Whi Specify:		
3	5-0036	ature!	ed by	3 Widowed	15. Decedent's	s Education	r or Dates:		16a. Decede	ent's Usi	al Occupatio	n		16b.	Kind of Business	Black Industry Un	
ta		le. Media	Completed	Elementary/Seco	ify only highest ndary (0-12)	1	eted) ege (1-4or 5-	+)	(Give k life. D	ind of w O NOT i	ork done duri use retired)	ing most of wo Unknow	rking N				
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3	Maryland	Department of Health and Mental Hygiene. importent: If item 273s or 28s-f ehow importent: If item 271s marked other than "naturel", or itams 23s or 28s-f ehow any injury or other treumatic event, it a Medical Exertire frust ke notified at once.	'	19a. Informant's Na						-					or Town, State,		ee (
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50	3alt i	Separtn mporte ny inju		21. Signature of Fa	neral Service	icens			22.	Name a	nd Address	f Facility	Anatomy	Gif	ts Regi	stry	
4				23a. Part1. Enter the	ne disease, or o	complications	that caused	the deaths							lanover,	Approxima	ate
	Pn	ysician į		shock, or hea Immediate Cause disease or condition	rt failure. List o Final	nty one caus	e on each lin	at	Ti 1	Lin	a (a	1100	_			Onset and	
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	e Hospit	within 24 hours after deatl To the Funerel Director: completely filled in by the	edicai (29a. Certifier (Check only one)	Certifying 2 Medical E	xaminer: On	To the best of the basis of manner sta	examination	rledge, death on and/or inv	occurre	d at the time, n, in my opini	date and plac on, death occ	e, and due to th urred at the time	e cause(e, date a	s) and manner and place, and du	s stated. e to the cause	(s)
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Examine		4a. Facility Name (if not institution, g		Hima	oke		r Location of Death	atu	4c. Co	unty of Death	
Funeral Director		5. Social Security Number 241 – 36 – 6997	5. Sex 7. Ag		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 06-19			place (State or Foreign
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s 23a or 28 uust be not	Funeral Dir	10e. Street and Number 2500 W. Belv	A	pt.#		10f. Zip Code 21215	5			of What Cou	ntry?
· - =	≥	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ★ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.			Vas Decedent of H Yes, specify Cuba		pecify Yes or No- o Rican, etc.)		Race - Americ Black, White, ecify: Ame	etc. African
21215-0036 within 72 hours after giene. the "hatural", o the Medical Exam.	Completed	15. Decedent' (Specify only highest Elementary/Seconday (0-12) 8th Grade		5+)	(Give F	lent's Usual Occup kind of work done o D NOT use retired) nsed Pr	during most of wor	ĭ		of Business In	_{dustry} morial Hos
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Baltimore, bermit. Page 1 and Department of Hea mportant: If item my injury or other pace.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			emetery, cren	sition (Name of natory or other place d Nat 1	09-	Date 28-10	Laur	ion-City or Ti	ID
Balt permit Depart Import any inj once.		21. Signature of Funeral Service Lic	ensee	>		. Name and Addre 38 N. G		ylie F			ne P.A. MD 21217
Medical Examiner		23a. Part 1. Enter the disease, or control shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	omblications that cause ly one cause on each lin aaauction	ite	Revo		g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
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of Vital Records, P.O. Box 68760 Physician: The law requires that the death certificate be extins certificate has been signed by the attending physician director, page 2 should be detached for use as the burity. To Re Completed by Physician Medical	iysiciali/imedic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d. 23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Feta	al death 3	Ectopic pregnand	су		23d	I. Date of deliv	rery Day Year
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Division of tall or Attending as after death. al Director: After ed in by the fune		3 ☐ Suicide 6 ☐ Could no determine				eet, factory, office		28f. Location (S City or Tow		umber or Rura	l Route Number,
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completed filled in by the Madical Certific	≥ -	(Check 2 Medical Exact only one) 3 Certifying N	Physician: To the best of aminer: On the basis of a lurse Practioner: To the	examination	n and/or invest	igation, in my opinion	on, death occurred e time, date and pl	at the time, date a ace, and due to the	nd place, and e cause(s) an	d due to the ca d manner as s	ause(s) and manner stated. tated.
		29b. Signature and title of certifier Guada	Quevo	MD		29c. License	s - 000			igned (Month, ember	20, 20/D
3		30. Name and address of person when $Gerardo$	GUECO, M	ID	SINAL	HOSPITA	L OF BA	LTIMORE		7	
State Registrar		31. Date filed (Month, Day, Year) SEP 2 2 201 0	32:-Registr	ar's Signat	- Sark						
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			1 - For State Registrar	State of	Maryland / [Departmei <i>Certifica</i>			and Mental I	Hygien		29699
	Physici /Medio		1. Decedent's Name (First, Middle ROSEMARY	A RODI					2. Date o Month SEP	7 10	ay Year 7 ZOIO	3. Time of Death
	Examir	ner	4a. Facility Name (If not institution Genesis Multi-			4b. City	Town, or TOWS	Location of	of Death	4	lc. County of Deat Baltimo:	
	Funeral		5. Social Security Number		7. Age (In yrs. last bir		r 1 Year	If Under	24 Hrs. 8. Date o	f Birth , <i>Day, Ye</i> a		nplace (State or Foreign
	Director		213–36–8517	1 □ M 2000F	95	Yrs. Months	Days	Hours	Min. (Month	$\operatorname{er} 1_{r}$	1914 Penn	^{uintry)} sylvania
	and W		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location						10d. Inside City Limits
	Maryli f sho	io	Maryland Balt:	imore		Towson						1 □ Yes ¾∑No
	r 28a-	Director	10e. Street and Number			10f. Zi	p Code			10g. C	Citizen of What Co	untry?
	th with	ai D	305 E. Joppa I	Road			2	1286			of Amer	
	tems	Funerai	11. Marital Status	Armed For		13. Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Ori In, Mexicar	gin? (Specify Yes on, Puerto Rican, etc.	r No-	14. Race - Ame Black, White	
36	urs aft	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 🔯 Divorced	ied 1 ☐ Yes If Yes, Giv Year or Da	9	1 Tes	2 🔀 No	Specify:			Specify: W	hite
21215-0036	i within 72 hours after death with the Maryland liene. r then "naturel", or Items 23a or 28e-f show The Medical Examiner must be notified at	Completed	15. Deceden	t's Education st grade completed)	16a.	Decedent's Use (Give kind of w	al Occupa	ation	t of working		Kind of Business/ Jnited St	
21	within ene. than "	mple	Elementary/Secondary (0-12)	College (1		life. DO NOT	ise retired	()		_	Post Offi	
	be filed v tal Hygie d other t event, In		12 17. Father's Name (First, Middle,	Last)	2 0	Clerk		18. Mothe	er's Name (First, Mic			
an	Q 5 D 9	To Be	Francis C. O'					M	lary Henzy	,	ŕ	
Maryland	d 2 should th and Men 7 Is marke treumatic	-	19a. Informant's Name/Relations	hip (Type, Print)	19b	-			er or Rural Route No			
	C = 0 L		Bonnie A. Jones	s/ daughte	the second second	-				-		MD 21030
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 Toremation		cemeter	f Disposition (Na ry, crematory or Fureral (other plac		September		Location - City or	
ltin		h	' 4 ☐ Donation 5 ☐ Other (S			⊇lAir			22, 2010	_		, Maryland
Ba	permit. Departr Importe any inji		Metok	1/					es Funeral d Timonium			
			23a, Part1 Enter the disease, or shock, or heart failure. List	complications that ca	used the death. Do nach line.							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		ERROU				ACCI		57	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):						0
	* *	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		or as a consequence		21					years
h."	cuted nd ransit	Examine	that initiated events	C								
8760,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequence	of):						
687	the death redificate be executed y the attending physician and tched for use as the bunat-transit	edical		d								
Box (ncing p	n/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy	۵۵۶۰۰۰					23d. Date of del	ivery
	deat od for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		rth 2 Fetal death ant at time of death	3 □Ectopic p 5 □ Other (s		-		_	Month	Day Year
P.0	that the de led by the a detached		9 Unknown Part II. Other significant condition			n the underlying	cause dive	an in Part I	23e. I	Did tobacco	o use contribute to	the cause of death?
Vital Records,	es Deg	d by	Dementi		<u>-</u>	and annually ang				1 🗌 Yes	2 □ No 3 □ Pr	obably 4 Uknown
COL	aw requir as been si 2 should	Completed								Was an	24b. Were au	itopsy findings available
Re	The ate h	omo								autopsy performed? es 2	death?	completion of cause of 2 No
/ita	sician: certifica irector, p	Bec	25. Was case referred to medical examiner?						of Death (Check o	nly one)		
of \	hys this	7 To	1 ☐ Yes 2 ☐ Ne 27. Manner of Death		npatient 2 ER/Ou		OA Othe	Br. ALM	irsing Home 5 1		6 ☐Other (Spe	cify)
OU	ding h. After fune	tion	J Natural 5 ☐ Pendin 2 ☐ Accident investig	9		njury M	28c. Injury Worl 1 ☐ '	k? Yes 2□		IDE HOW III	quiy occurred	
Division of		Certification:	3 Suicide 6 Could in determine	not be 28e. Place	of Injury - At home, fa	ırm, street, facto	y, office			on (Street r Town, Sta		ıral Route Number,
Ö	ital or A											
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical			best of my knowledge sis of examination an							
	Fo the within 2 Fo the comple	Me	29b. Signature and title of certified		07 01010-01	29	c. License	e number			Date signed (Mont	
			\$	upte MC)	L	00	53	150	5E	P7 19	2010
	A		30. Name and address of person	who completed cause	of death (Item 23a)	CT D: 0			10	5011	e 110	2010 MD 2045
	Sta	-	31. Date filed (Month, Day, Year)	010 3/R	o of death (Item 23a)	A. D.	14/6	-20	1-0	601	mble	0043
	Registr	ar	SEP 2 2 2	UIU KEN	wa p.	gare						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #15bate or Marviand / Department of Health and Mental Hygiene

		1- For State Registrar Reg. No. 2010	29700
Physicia Medical Examin		1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Tim	e of Death
iviedicai Examir	ner	Cecil L. Roland September 16, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	43 hrs
		Maryland General Hospital Baltimore	
Funeral Director			(State or
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. In	side City Limits
und show	'n	MD Middle River	Yes 2 X No
h the Maryla 3a or 28a-f	Director		
0	Funeral	1 3 Widoword 4 Divorced lift Yes Give Year 1 4 Yes 0 Kh Ne seeds:	
ours afi atural'	d b	15 December 5 duration (Consider the total and the Consider tion the Consid	
1036 vithin 72 ho ene. rr than "na Medical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Security Officer Security	
21215-0036 July be filed within 7 Mental Hygiene, marked other than ic event, the Medica	اه	dirk	_
212 ould be d Ment s mark	ToB	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co.	de)
e, MD 1 and 2 sho Health and item 27 is		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, S	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		1 K Burial 2 Cremation 3 Removal from State Crownsville Vet 9-24-2010 Crownsville 4 Donation 5 Other Specify: 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility March East F/H	, MD
Ba Depression in just		1101 E. North Avenue Balto, MD	21202
Physician		failure. List only one cause on each line.	een Onset and
Examiner	1	Immediate Cause (Final disease or condition resulting in death) a. Cocaine and alcohol intoxication Due to (or as a consequence of):	Death
	<u>_</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):	
Transit on &		events resulting in death) Last Due to (or as a consequence of): d	
760, cate be executed physician and he burial - transit	Medical	☐ AMEABED, 27, 28a-f, per ME g908 10/4/10 TT	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the timeral director, page 2 should be detached for use as the burial - transit.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	Year
the dea	ᇍ	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the caus	e of death?
ls, P.O. quires that the en signed by roll be detach	2	1 Yes 2 No 3 Probably 4	Unknown
Records The law requi	Completed	24a. Was an autopsy fin autopsy performed? 1 Yes 2 No 1 Yes	
ital Recician: The scertificate rector, page	Be Be	25. Was case referred to medical examiner? Hospital: Inpatient 2 FR/Outpatient 3 DOA Other 1 Nursing Home 5 Residence 6 Other	
n of Viding Phys	<u> </u>	1 Ves 2 No Constitution 1 Inpatient 2 ER/Outpatient 3 DOA Outperful Nursing Home 5 Residence 6 Other: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) (Month, Day, Year)	
ion (tending eath. for: Af	틸	1 Natural 5 Pending Resident Prestigation Fd 9/16/10 Fd 4:30 am 1 Yes 2 No unk	
Divis pital or At uns after d eral Direct	Certification:	3 Suicide 6 Could not be determined Coperation of the Homicide Could not be determined Coperation of the Homicide Coperation of t	Number, City AVE
Division To the Hospital or Attend within 24 hours after death To the Funeral Director completely filled in by the	<u></u>	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(and manner stated.	5)
F > F 0	ž	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day,	Year)
A	-	30. Name and address of person who completed cause of death (Item 23a)	
\emptyset		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Sta Registra	te	1 SELLO O DOMO LA	

Amend 20b, per Fh g908 10/28/10 TT
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #29d Per Phy G908 10/22/10 Jh
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 20 i 3:43 Margaret Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** S. Culver street Baltimore Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Days Hours Min. 04/30/ 238-44-7422 Director 76 1934 Carolina Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits be filed within 72 hours after death with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director 1 X Yes 2 No MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 23 S. Culver Street 21229 .S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 ☐Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than mentary/Seconday (0-12) College (1-4 or 5+) 12th Grade <u>service order writer</u> Telephone Co Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည James Moody Flowers unk permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia Milhous(daughter) 19 Culver Street, Baltimore, MD 21229 S. 20b. Place of Disposition (Name of Arbiretrs crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hill Cedar 09/14/10 cem. Baltimore, MD Joseph H. Brown Jr. Funeral Home PA 2140 N Fulton Ave., Baltimore, MD 21217 any inj 21. Signature of Funeral Service Licenses liams 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final End stark Cardi um yopally Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death q Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should I 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy after death.

Director: After this certificate Yes 2 No 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: 2 No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d, Describe how injury occurred 5 Pending iniurv 1 Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 29**d C120** 2010 Day, Year) 29b. Signature and title of certifier MS Ray upowneM. D D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N-5- Rujufal Semp 2833 Smith M - 5-203 - Bulth nm, N-3- Kyupalsemp 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 2 2 2010 Registrar

DHMH 17 Rev 7/2009

10-07062

ryan Sanders	1	State of Maryland / Department of Health and M	Mental Hygi	iene Reg. N	2010	29702
Physicia	n/	Registrar 1. Decedent's Name (First, Middle, Last)		Date of Death	v Year	3. Time of Death 0155 hrs
/ledical Examir		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loc		September 1	4c. County of Death	
,		Union Memorial Hospital Baltimore			VA	the local (Choice on
Funeral Director		214-90-9012 1 M 2 F W Yrs. Months Days	If Under 24Hrs. 8 Hours Min.	By Sale of Birth (N	MM/DD/YYYY) 9. Bir Foreig C	MASSI
hours after death with the Maryland natural", or items 23a or 78a-f show any Examiner must be notified at once.	al Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. Street and Number 10f. Zip Code 22 22 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispan	nic Origin? { Speci		Citizen of What Coul	10d. Inside City Limits 1 Yes 2 No htry?
rs after death w ural", or items miner must be	by Funeral	1 Never Married 2 Married Arpred Forces? If Yes, specify Cuban, Med 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation	Mexican, Puerto Ric	can, etc.)	White, etc. Specify: DA b. Kind of Business/	ack Industry
036 vithin 72 ene. er than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) SMID REDAIL		4	ATMOST.	VACAT CLUE
	Be Co	17. Father's Name (First, Middle, Last) 18.N	July	MAL	ONE_	
y, MD 2121 and 2 should be fil lealth and Mental I tem 27 is marked traumatic event,	2	ROMAD A. GANDERS 4205 GELS	3 TON TR	WE PA	City or Town, State	21279
ore, as lan of Heal If iten		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify	9-21	-10 C	AMBUILL	Town, State
Baltimo permit. Page Department Important: injury or of	10.0	21. Signat of Funetal Sprice is expressed and Address of Spring S	CH FURT	PAI HOM	YIL A TO	21224 71,000
Physician /Medical Examiner		23a. Per la the disease, or complications that caused the death. Do not enter the mode of dying, such failure. List only one cause on each line. Immediate Cause (Final disease a. Cirrhosis of the Liver	ich as cardiac or re	espiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death
LAAIIIIICI		or condition resulting in death) Due to (or as a consequence of): Chronic Alcoholism				
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		<u></u>		
xecuted n and transit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.				
ra e e	dical	▼ UNPENDED ☐ AMENDED 23a,b,27 per me g912 2-	-2-11 vt			
ords, P.O. Box 68760 aw requires that the death certificate be table been signed by the attending physical should be detached for use as the bu	sician/Me	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	Ectopic pregnanc	у	23d. Date of deliver Month	y Day Year
P.O. BC es that the dea igned by the a be detached for	by Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the bu	Completed			24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
ital Re(ician: The scertificate	8	examiner? Hospital: 4 to a time to a find the spital and the spita	f Death (Check onl		sidence 6 Othe	or:
n of Viding Phys	on: To	1 V Yes 2 No III Input of Injury 28b. Time of Injury 28c. Injury a (Month Day Year)	·		injury occurred	··
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office build (Specify)		Bf. Location (Stre or Town, State		ural Route Number, City
he Hosi in 24 hc he Funs		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de	e and place, and du death occurred at th	ue to the cause(s he time, date and	i) and manner as sta d place, and due to t	ted. ne cause(s)
To t with: To t	Medical	and manner stated. 29b. Signature and title of certifier 29c. License n O.C.M.	number	2	9d. Date signed (Mo	onth, Day, Year)
4		30. Name and address of person who completed oduse of death (Item 23a)				
Ψ		Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Bo	Baltimore, MD	21201		
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

		,	1 = For Amend Item Registrar	State of per	Maryland Verb.,	g 907 96 Cer	ነ ታምድሃ 25 1 tificate of L	balth an Death	d Mental Hy	giene Reg. No 2 0 0	29703
6			1. Decedent's Name (First, Middle, Last			-			2. Date of De Month		3. Time of Death
	Physici /Medi		Betty			57	Ntin		August	24 2010	19 12 PM
	Examir		4a. Facility Name (If not institution, give	street and numb	per)		4b. City, Town, or		eath .	4c. County of De	ath
			The Johns Hopkins Ho				Baltimore		Ti la		
	Funeral Director		5. Social Security Number 6. Se 214-54-5865	м 2 Ж	'. Age (In yrs. Ia 60	st birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bir (Month, Date 11/27)	ay, Year) C	irthplace (State or Foreign ountry) MD
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation				10d. Inside City Limits
	laryland s show d at	5					oation				1 ▼ Yes 2 □ No
	the N 28a-1 otifie	Director	MD 10e. Street and Number		Balt	imore	10f. Zip-Code			10g. Citizen of What C	
	with be n	ä	1723 Cathedral St	root							, out my i
	ns 23	era	11. Marital Status	12. Was Deced	lent Ever in U.S	. 13. \	21201 Was Decedent of H	ispanic Origin	? (Specify Yes or No	U.S.A. 14. Race - An	nerican Indian,
36	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 23a-f show yent, the Medical Examiner must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Ford 1 ☐ Yes If Yes, Give Year or Dat	ces? 2 X No		f Yes, specify Cuba I ☐ Yes 2 🏋 No	n, Mexican, P Specify:	uerto Ricán, etc.)	Black, Wh	ite, etc. Vhite
2-0036	tural	ed	15. Decedent's Ed	cation			lent's Usual Occup			16b. Kind of Busines	ss/Industry
13	nin 7% n "ne Aedic	Completed	(Specify only highest grad	e completed) Callege (1-4	or 5+)		kind of work done OO NOT use retired		working	ľ	
2121	filed withir Hygiene. kther than int, the Me	, E	12	- College (0, 0, 7	Home	emaker			Own Home	
p	hould be filed within 72 ho d Mental Hygiene. marked other than "natumatic event, the Medical	Be C	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle	e, Maiden Surname)	
Maryland		မ	Samuel J. Woodham							Schofield	
a	d 2 should the and Ment of is marked traumatic e		19a. Informant's Name/Relationship (Ty	pe. Print)		19b. Mailir	ng Address (Street	and Number o	or Rural Route Numb	ber, City or Town, State	, Zip Code)
	D 華 2 T		Michael Law (Broth	ner)				n, Mid	dleriver,		
e C	of of the second		20a. Method of Disposition 1 ☐ Burial 2 📉 Cremation 3 ☐ I	Removal from St	ate ce	emetery, cren	sition (Name of natory or other plac		Date	20c. Location - City	or Town, State
Ĕ	Pages ment of I ant: If ite ury or of		4 ☐ Donation 5 ☐ Other (Specify)		At		crem.	8,	/29/2010	Glen Burn	ie, MD
baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Euneral Service License	Hen	ed l	22 / Sk	Name and Address Narda F.H	ss of Facility	2829 Hudso Baltimore	on Street, , MD 21224	
			23a Part 1. Enter the disease, of composhock, or heart failure. List only or	ications that car	used the death.						Approximate Interval Between
le)	Physician	S 0	Immediate Cause (Final	~	25 t ³ 5						Onset and Death
1	/Medical		disease or condition resulting in death)	d	r as a consequ	ence of):					
	Examiner		Conventielly list conditions	n –					•		
		ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (c	r as a consequ	ence of):					
	cate be executed bhysician and the burial-transit	Examiner	that initiated events	o							
5	e exe		resulting in death) Last	Due to (o	r as a consequ	ence of):					
5	ate be nysici the bi	dical		d							-
00/00	rtifica ng ph e as t		IF FEMALE:			-					
POY	leath certifi attending d for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?		th 2 🗌 Fetal	death 3	Ectopic pregnanc	у		23d. Date of o	delivery Day Year
	e dea he at hed f	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4 🔲 Pregna 9 🗍 Unkno	int at time of de wn	ath 5∟	Other (specify)				
ŗ.	at th		Part II. Other significant conditions co	ntributina to de	ath but not resu	ultina in the u	ınderlvina cause ai	iven in Part I.	23e, Did	tobacco use contribute	to the cause of death?
oi vitai necorus,	law requires that the death certificate be executed as been signed by the attending physician and 2.2 should be detached for use as the burial-transis	ed by							_ 1 🗆	Yes 2 ☐ No 3 ☐	Probably 4 nknown
္ဌ	aw requ s been 2 shou	Completed							24a. Was		autopsy findings available to completion of cause of
ב	0 <u> </u>	E				_			perfo	ormed? death	? es 2 🗆 No
ā		Be C	25. Was case referred to medical					26. Place of	Death (Check only of		
>		면 면	examiner? 1 🗀 Yes 2 🔀 No	lospital: 1X In	patient 2 🗆 E	ER/Outpatien	t 3 DOA Oth	er: 4 🗌 Nursir	ng Home 5 🗆 Resi	idence 6 🗌 Other (Sp	pecify)
2	g Phy er this neral d		27. Manner of Death ↑ Antural 5 ☐ Pending	28a. Date of	Injury Day Year)	28b. Time of Injury	f 28c. Injur Worl	y at	28d. Describe	how injury occurred	
2	Attending or death. sctor: After by the fune	atio	2 ☐ Accident investigation	(month)	, Day 10a.)	,,		Yes 2 No		_	
	I or Attend after death Director: \ d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place o building	of injury - At hor g, etc. <i>(Specify)</i>	ne, farm, stre	eet, factory, office			(Street and Number or wn, State)	Rural Route Number,
_1	olital o		29a. Certifier 1 ☐ Certifying Phy	sician: To the h	est of my know	ledge death	occurred at the tir	me date and r	place, and due to the	e cause(s) and manner	as stated.
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Medical			sis of examinati					e, date and place, and	
	To the within 2 To the Comple	Me	29b. Signature and title of certifier				29c. License	e number		29d. Date signed (Mo	nth, Day, Year)
			Mu X	ten			RES.	-000		August 24	2010
	/		30. Name and address of person who c	-	e of death (Item	23a) (Type,	Print)			3	
	,		Kevin So	eres	distracts of set	WO /	/	6	00 North We	olfe St, Baltin	nore, MD, 21287
	Sta Registr	ite rar	31. Date filed (Month, Day, Year) SEP 2 2 20	10	istrar's Signatu	B. A	backer				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ William Andrew Stetka, Sr. 35A M 2010 0 Medical Sept 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 7. Age (In vrs. last birthday) Months Days Hours (Month, Day, Year, 220-20-3676 1 🔀 M 2 🗆 83 Baltimore, Maryland Director 1927 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at death with the Maryland Director Forest Hill Maryland Harford 1 Yes 2 XNo 10f. Zip Code 10g. Citizen of What Country?
United States 10e. Street and Number Funeral 21050 115 Forest Valley Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or Completed by Yes 2 X No Yes, Give Maryland 21215-0036 1 ☐ Yes 2**X X**No Specify: White 3 Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Liquor Distributor Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elsie V. Johnson Joseph F. Stetka 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 Forest Valley Drive Forest Hill, MD 21050 19a. Informant's Name/Relationship (Type, Print) William Stetka, Jr. (Son) permit. Page 1 and 2 Department of Healt Important: If item 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel Bel 22,200 Forest Hill, Maryland 22. Name and Address of Facility
Evans Fureral Chapel & Cremation Services Bel Air

The Property of the Proper Signature of Funeral Service Licensee 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. En let the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final ardiocespiratory Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical MSCO384734 Division of Vital Records, P.O. Box 68760– IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ☐ Yes 2 🕱 No 1 ☐ Yes 2 ☐ No Be B 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{\text{\text{Nursing Home}}}\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 ☐ Yes 2 🗶 No ျ 1 Npatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hin 24 hours afte the Funeral Dire mpleted filled in b Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the Comple only one) 29b. Signature and title of certifier 29c. License number 63420 he Won JX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) upper inelapeake Dr, Bel Hir, MD 21014 Kharal 500 31. Date filed (Month Pay, State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, ITEM#11 perFH, C941, 7/25/2013, WS State of Maryland, Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Delores -28 PM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1472771941 S.Carolina 1 □ M 2 🗓 F 68 21836 122 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exymination at once. Director 1X Yes 2 ☐ No MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9212 Oswald Way U.S.A. 21237 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2★No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. If Yes, Give Year or Dates ⋧ Specify: 3 Widowed Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade clerk U.S Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Morgan Rebecca Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Tyler (son) 38 Broadridge Rd., Baltimore, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of Date Legislatory of other plants of the plants of 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State ~F′/H 09/17/10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 30 Minutes Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed sician and burial-trans Mra ventri Due to (or as a consequence of) Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 No Month Day Year 5 ☐ Other (specify) ned by the a P.O. 9 Unknown 9 Unknow signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by cate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ∐Yes 2 X No 2 🗷 No of Vital 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A investigation filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number riville 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Boulevard, Baltimore Maryland 21239 31. Date filed (Month, Day, Year) State SEP 2 2 2010

DHMH 17 Rev 1/2001

Registrar

inda Tyler		1- For State	St	ate o	f Maryla	nd /		tment o ficate o	f Health a f <i>Death</i>	nd Men	ıtal Hyg		eg. No.	201	0	29706
Physicia		Registrar 1. Decedent's Name	e (First, Midd	le,Last)								Date of Deat	th Day	Year	3.	Time of Death
Medical Examir		Linda		Mae			ler					Septembe	r 15,	2010		1121 hrs
		4a. Facility Name (i 2213 Westfi		_	street and nu	mber)			4b. City, Town, Baltimore		of Death		40	c. County of De		
Funeral Director								_	8. Date of Bir			Birthp reign Count				
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th the Maryland 23a or 28a-f sho notified at once	Ä	2213 We		าล	7.370					214			-	S.A.		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rout of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Funeral Director	11. Marital Status			12. Was Dec		ver in U.S.		is Decedent of I	Hispanic Orig						Indian, Black,
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ore, hest and of Healt If item		20a. Method of Disp 1 Burial 2		n 3 [Removal fro	om State			Brown atory		,	Date		Location - City		
Baltimore, permit. Pages 1 at Department of Het Important: If ite Imjury or other tr	ļ	4 Donation 5 21. Signature of Fu			.)		And							ltimo	_	100
Bal permi Depa Impo		21. Signature of Fu	IRA I	N.L	1 Jelle	Lu	em	21	lame and Addre OSEPN 40 N F	H. B.	rown n Av	Jr. l e.,Ba	Fur Iti	more,	Hor MD	ne PA 21217
Physician	Ť	23a. Part I. Enter th				aused th	e death. D									Approximate Interval Between Onset and
Medical Examiner		Immediate Cause (or condition resulting			Comp1 ue to (or as a			of li	ver dis	sease			_		+	Death
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cuted and transit	Ě	events resulting in	death) Last	d.	ie io (or as a	conseq	derice dr).								\perp	
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8760 ficate g phys s the by	ΣI	IF FEMALE: 23b. Was decedent			23c. If yes, o	outcome	of pregna	ncy			c pregnanc	:v	23	d. Date of deli	very Day	Year
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Division of Vital Records, pital or Attending Physician: The law require ours after death.	Certification:	2 Accident 3 Suicide	6 Cou	stigation Id not be rmined	28e Place	e of Inju	ry - At hom	ne, farm, stre	et, factory, office	e building, et	tc. 28	8f. Location (S or Town, S		and Number or	Rural	Route Number, City
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bara	}	30. Name and addr			mpleted caus				Street, Balti	more, MD	21201		1			
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ORIGINAL

	1- For State Registrar	d / Department of Certificate of			eg. No. 201	0 29707	
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Isaiah White Jr.			2. Date of Dea Month	Day Year	3. Time of Death 0510 hrs	
	Isaiah White Jr. 4a. Facility Name (if not institution, give street and numb	er)	4b. City, Town, or Location of		er 19, 2010		
	Sinai Hospital		Baltimore		N/A		
Funeral Director		Age (In yrs. last birthday)	If Under 1 Year If Under Months Days Hours	N.C.	rth(MM/DD/YYYY) 9.	Birthplace (State or eign	
Director	216-15-1634 1KM 2 F	24 Yrs		03/26		Country) MD	
ŕ	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Locat	on			10d. Inside City Limits	
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3a or Otified	9909 Southall Road		21133		U.S.A.		
r death with the Marylanc or items 23a or 28a-f sh must be notified at onc Funeral Director	11. Marital Status 12. Was Decede 1 X Never Married 2 Married Armed Force		s Decedent of Hispanic Orig es, specify Cuban, Mexican,	in? (Specify Yes or No		erican Indian, Black,	
r mus	1 Yes 3 Widowed 4 Divorced If Yes, Give Year	2 X No	Yes 2 X No specify:	rasits Moan, etc.)			
urs aft tural" amine	15. Decedent's Education (Specify only highest grade c		t's Usual Occupation (Give F	and of work done	Specify: B1		
5-0036 ed within 72 hour lygiene of ther than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 c	during me	ost of working life. DO NOT	use retired)	January Basines	o madou y	
within iene.	10th Grade	Const	ruction Wo	rker	Temp Ag	ency	
21215-0036 Menal Hygiene marked other than "matural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once.	17. Father's Name (First, Middle, Last) Isaiah White Sr.		1	s Name (First, Middle, N	,		
	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Vero Address (Street and Num	nica Mish			
MD d 2 sho th and th and 17 is aumatic	Veronica Parker(mothe		Southall R				
imore, MD 2 Pages 1 and 2 shou ment of Health and N Tant: If item 27 is n or other traumatic	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from 9	20b. Place of Disposi	tion (Name of cemetery,	Date	20c. Location - City	or Town, State	
imo Page ment cant tant: or ott	4 Donation 5 Other Specify:	Mt. Zior	cem.	10/01/10	Baltimor	e,MD	
Baltimore, permit. Pages 1 an Department of Heal Important: If iten injury or other tra	21. Signature of Funeral Service Licensee	22. N	ame and Address of Facility Seph H. Br 40 N FULTO	own Jr. F	Uneral H	ome PA	
	23a. Part I. Enter the disease, or complications that cause	ed the death. Do not enter th	40°N FULTO e mode of dving, such as ca	n Ave., Ba	altimore,	MD 21217 Approximate Interval	
⊶ /Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Gunshot Would		7.5	, , , , , , , , , , , , , , , , , , , ,	,,	Between Onset and Death	
	or condition resulting in death) Due to (or as a con						
<u>-</u>	Sequentially list conditions, b	sequence of):					
	cause. Enter Underlying Cause						
d ansit	events resulting in death) Last Due to (or as a con	sequence of):					
Division of Vital Records, P.O. Box 68760, to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial -transit edical Certification: To Be Completed by Physician/Medical Exc	UNPENDED AMENDED						
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of Vital Records, ng Physician: The law require ther this certificate has been signered director, page 2 should be 1: To Be Completed			.	24a. Was a autops	sy prior to	utopsy findings available completion of cause of	
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Division To the Bospital or Attend within 24 hours after death within 24 hours after death. To the Puneral Director: completely filled in by the Medical Certification	check only Certifying Physician: To the best of n Medical Examiner: On the basis of examiner:	ny knowledge, death occurre amination and/or investigatio	ed at the time, date and place n, in my opinion, death occu	e, and due to the cause irred at the time, date a	e(s) and manner as sta nd place, and due to t	ted. ne cause(s)	
2 P P 2	and manner stated 9 Signature and title of certifier		29c. License number		29d. Date signed (Mo		
O.C.M.E. September 19.							
30. Name and address of person who completed cause of death (Item 23a)							
	/		11 Penn Street, Balt	imore, MD 21201			
State ³ Registrar	SEP 2 2 2010	ar's Signature parks					

			State of Maryland / Dep	artment of Health and N	Mental Hygid	ene					
		1 - State Registrar Certificate of Death Reg. No. 2010 2971									
	Physicia		1. Decedent's Name (First, Middle, Last) Arthur E. Wol	f	2. Date of Death Month September	Death 3. Time of Death mber 20,2010 6:00A M					
- 4	Medic		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Бересшве	4c. County of Death					
_2	,		520 Mayo Road	Glen Burnie		Anne Aruno	del				
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 072-07-6251 7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Xi Aug. 9, 19	9. Birthp (ear) Count	lace (State or Foreign Yy) New York				
			Usual Residence of Decedent		Aug. 9, 19	10	New TOTK				
	/land f sho	ţo	10a. State 10b. County 10c. City, Town or L	ocation		1	0d. Inside City Limits				
	Mary 28a- notifie	Director	MD Anne Arundel Glen B				1 🗆 Yes 2 🔼 No				
	ith the	rai	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun	try?				
	ath w	Funeral	520 Mayo Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21061 Was Decedent of Hispanic Origin? (Spe	ocify Yes or No-	U.S.A.	an Indian				
စ္	ter de or ite	by F	1 ☐ Never Married 2 【XMarried Armed Forces? 1 X Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, e					
8	urs af tural" al Exa	ted	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2X No Specify:		Specify: Whi	te				
15	72 ho 1 "nat ledica	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	ng	6b. Kind of Business Inc	lustry				
712	vithin jiene. pr thai		Flementary/Seconday (II=12) (Iollege (1=4 or 5±)	OO NOT use retired) Of actor/Intelligence	ficer	Armed F	orces				
br	filed val Hyg	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	iden Surname)	_				
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ပ	Elmer Edwin Wolf	Bertha	Louis	se Stang	e				
Mar	shou h and 7 is m rraum			ing Address (Street and Number or Rura		ity or Town, State, Zip C	ode)				
e,	and 2 Healt tem 2		Mr. Randy Wolf / Son 16 20a. Method of Disposition 20b. Place of Disp	905 Heritage Hill		Henderson Oc. Location - City or To	MD 21640				
nor	age 1 ent of nt: If ii		1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre		. 22, 2010	Crownsvill					
alt:	mit. P partm portar / injur			2. Name and Address of Facility 1 2:	nd Avonue						
m	permir Depar Impor any ir once.	0 4	1 / alth M Jeff mo1580	Singleton Funeral	& Cremati	on Services	s, P.A.				
_	Physician/		23a. Vart 1. Enter the disease or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	er the mode of dying, such as cardiac of	or respiratory arrest,	ence	Approximate Interval Between Onset and Death				
-	Medical Examiner		resulting in death) Due to (or as a consequence of):	Pilwre		1	Was a				
H		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence pi):	Jan or (- years				
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	elanoma			4 years				
	ate be executed ohysician and the burial-transit	E	resulting in death) Last Due to (or as a consequence of):				1				
90	death certificate be executed ne attending physician and ed for use as the burial-transi	dical	d								
68	eath certifica attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	n/				
Box 687	eath c atter d for u	icial	in the past 12 months? 1 ☐ Ves 2 ☐ No 1 ☐ Ves 2 ☐ No 1 ☐ Ves 2 ☐ No	Ctopic pregnancy Other (specify)			Day Year				
C H	t the d by the tacher	Phys	9 🗆 Unknown 9 🗀 Unknown		1						
, P.O	requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	e cause of death?				
Records,	requir been s should	Completed				<u> </u>	sy findings available				
ecc	e has l	dmc			24a. Was an autopsy performe	prior to con death?	npletion of cause of				
<u>=</u>	sician; The la certificate ha irector, page 2	a l	25. Was case referred to medical	26. Place of Death (Check		No 1 ☐ Yes	2 LJ No				
Ĭ	hysici lis cer l direc	일 일	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	nt 3 DOA Other: 4 Nursing Ho	me 5 Residenc	ce 6 Other (Specify)					
o c	ing Pl		27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury injury injury	work?	28d. Describe how	injury occurred					
Sior	death death ctor: / y the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	OSE Landing Office	at a sed Alicentes as a Florent	Davida Niverbara 1				
Division of Vital	al or A s after I Direction by		4 ☐ Homicide determined 256. Place of Injury - At nome, farm, sti building, etc. (Specify)	eet, factory, office	City or Town, S	et and Number or Rural (State)	Houte Number,				
	To the Hospital or Attending Physician; The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination and/or invest	occured at the time, date and place, an tigation, in my opinion, death occurred at	d due to the cause((s) and manner as stated	f. se(s) and manner stated				
	o the l	Ĕ	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the time, date and place 29c. License number	e, and due to the ca	use(s) and manner as sta	ted.				
	F S F O		29c. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 1/4 29c. License number 29d. Date signed (Month, Day, Year) 1/4 29d. Date signed								
14	(30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) 305 Hos	Pita	> Drive	21061				
1	Stat Registra	E	31. Date filed (Month Day, Year) 2010 Registrar's Signarate Aa	who were	() ~						

/DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Physician/ Month 11:00 AM 09 MANTILE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 24 Hrs. 8. Date of Birth Hours Min. Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 **M** M 2 □ F 62 5767 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland **Funeral Director** Baltimore 1 **XO**/es 2 □ No MD10g. Citizen of What Country? 10e, Street and Numbe 21229 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 PNo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retire) 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other t any injury or other traumatic event, the once. Be မ on 19b. Mailing Addre (Fiance on Kd 20b. Place of Disposition (Name of 20a, Method of Disposition cemetery, crematory Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Medical Examiner Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of) as the burial-transit The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ρ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown be detached g Unknown P.O. þ Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy 1 ☐ Yes 2 ☐ No certificate Yes 25. Was case refer d to medi a within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** 26. Place of Death (Check only one) Hospital or Attending Physician: Be examiner? 2 🔀 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 00522 43 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) State SEP 2 2 2010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 1:15 12M 2LIAM ムノルム左丁丁石 SEPTEMBER 16 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** more 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗙 F Months Days Hours Min 213-72-7139 Director Vov 13 1957 Usual Residence of Decedent death with the Maryland a or 28a-f show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director 1XYes 2 No timore 10e. Street and Number 10g. Citizen of What Country? Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a
any injury or other traumatic event, Its Medical Examination of price. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Mever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>م</u> Specify. 3 ☐ Widowed 4 ☐ Divorced ac Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Baker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore MD 21216 MONT wenue 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State Baltimore, MD -10 4 Donation 5 ☐ Other (Specify) e of Fune eene 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HEPATIC ENCEPHALOPATHY /Medical Due to (or as a consequence of): Examiner IVER EIRRHOS13 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit law requires that the death certificate be executed 圧州台の仁ノム州 PULMONAR) Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 ficate has been siç r, page 2 should b ANIFATIA 1 Yes 2 No 3 Probably 4 Unknown Completed 20HO2 MBUKE 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy certificate 2 No 2 🗆 No Division of Vital 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) September 18 2010 D13300 MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ・ も こん と と しんら

State Registrar SUDKIR

filed (Month,

(Month, Day, Yea 2 2 2010

DHMH 17 Rev 1/2001

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32. Registraris Signature

0-06874		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.							
helma Jame V	State of Maryland / Department of Health and Mental Hygiene								
		1- For State Certificate of Death Reg. No.	10 27111						
Physici Medical Exam			3. Time of Death ar 1445 hrs						
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County 6007 Majors Lane # 9 Columbia Howard							
Funeral Director	217-91-3086 1 M 2 F 37 Yrs. Months Days Hours Min. Oct 4,1972 FORES								
Maryland 28a-f show any d. at.once.	Director	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 Yes 2 No						
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.	Funeral Dir	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 1 Yes 2 No	e, etc.						
hours after 'natural'', Examiner	þ	3 Widowed 4 Mulvorced in res, sive rear or Dates: 15 Decedon's Education (Specify only bishort grade completed). 160 Decedon's Rejust Occupation (Give kind of work done. 165 Kind of Rejust Occupation (Give kind of Rej	usiness/Industry						
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21215-00 nuld be filed wit Mental Hygien marked other c event, the M	To Be C	GERGE WINN INDERV							
and 2 lealth tem 2 traum	, I	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location	75_ MD, 21229 - City or Town, State						
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr		1 Denation 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility	3 VI/12 MD						
Physician Physician		23a Path, Internet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he	Approximate Interval						
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ted	Examiner	events resulting in death) Last Due to (or as a consequence of):							
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Box 68760, e death certificate be ex the attending physician ed for use as the burnal	ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Day Year						
P.O. E es that the digned by the	d by Phy	1 Yes 2 ✓ No 3	ibute to the cause of death? Probably 4 Unknown						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Completed	24a, Was an	Were autopsy findings available prior to completion of cause of death? Yes 2 No						
cian:	Be	25. Was case referred to medical 26. Place of Death (Check only one)							
Physical direction	입	1 Yes 2 No I inpatient 2 Exocupation 5 500 4 Noising notice 5 Nesidence 5							
Sion O Attending death. ector: Afte	ertification:	27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident Pending Investigation Sep 7, 2010 1445 hrs 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 5 Subject assaulted Subject assaulted Subject assaulted							
The standard of the standard o									
H S I S S S S S S S S S S S S S S S S S									
	2	29b. Signature and title of certifier 29c. License number 29d. Date sign September	r 8, 2010						
20		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
9	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature 4							

DHMH 17 Rev 1/2001 OCME 2006

OCME

			For	State of Marylan				lental Hygien	ne O O I O	00710
			Registrar 1. Decedent's Name (First, Middle, La.	et)	Cer	tificate of D	eath	Reg. N	Ng.	29/12
Pł	nysicia Medic		RUTH	WRIGHT					Day Year	3. Time of Death
) =	xamin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	,
	ineral ector		220-111-1711	ex 7. Age (In yrs. le	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birt	hplace (State or Foreign untry)
land	show d at	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City	/, Town or Loc	ation				10d. Inside City Limits
ne Mary	or 28a-f notifie	Direc	10e. Street and Number		BALTI	nors		100 /	Citizen of What Co	1 Yes 2 No
n with th	nust be	Funeral Director	1510 W. MOSA	BR ST MN	,	212	47	Tog. V	4,9,A	unity:
o ter deat	"natural", or items 23a or 28a-f show edical Examiner must be notified at	by Fu	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No			spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
215-0036 in 72 hours after e.	atural" cal Exa	eted	3 Widowed 4 Divorced 15. Decedent's E	If Yes, Give Year or Dates.		Yes 2 No		16h	Specify: Specify: Specify: Wind of Business	ACK Industry
Pi 7	r than "n the Medi	Completed	(Specify only highest gr Elementary/Seconday) (0-12)	College (1-4 or 5+)	(Give k	ind of work done do NOT use retired)	uring most of worki	ng Tob.	VE GLA	39 Q
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Tary should and M	27 is mar r traumati	İ	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	g Address (Street a	nd Number or Rura	Route Number, City	or Town, State, Zip	130 (7+7
lore, ge 1 and t of Hea	or other		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State		sition (Name of atory or other place		Date 20c.	Location - City or	Town, State
Baltimore, permit. Page 1 and Department of He	Important; any injury once.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Licent		1/1 A/	Name and Addres	s of Facility	7-10 G	11-1045 X	2NE / 1/1
. ao.	= 80		23a. Part 1. Enter the disease, or com shock or heart failure. List only c	plications that caused the death	n. Do not ente	r the phode of dying	, such as cardiac o	r respiratory arrest,	MR JINY	Approximate Interval Between
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uted	ansit	amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a orbsequ	ence of):	nel fe	alter			iusk
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oo/o	ise as th	n/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar					23d. Date of del	İveny
• BOX ne death of	ched or u	nysicia	in the past 12 months? 1 □ Yes 2 ◯ No 9 □ Unknown	1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		Ectopic pregnancy Other (specify)	/		Month	Day Year
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Financial Director After this certificate has been signed by the attending physician and	d be deta	Completed by Physician/Me	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the ur	nderlying cause give	en in Part I.			the cause of death?
e law requires	le 2 shou	mplete						24a. Was an autopsy performed?	prior to o	topsy findings available completion of cause of
ian: The	stor, pag	Be Co	25. Was case referred to medical examiner?			26. Pla	ce of Death (Check	1 ☐ Yes 🖎		2 🗆 No
OI VICAL ig Physician	eral direc	유	1 ☐ Yes 2 🖾 No 27. Manner of Death		ER/Outpatient 28b. Time of	Other	4 ☐ Nursing Ho	me 5 Residence		ify)
VISION C or Attending fter death. lirector: Afte	the func	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b	e	injury	M 1 🗆	res 2 No			
tal or Al	led in by		4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre	et, factory, office	Į.	28f. Location (Street a City or Town, Sta		ral Route Number,
the Hosp iin 24 hou he Finer	npleted fil	Medical	(Check 2 Medical Exam	sician: To the best of my knowle iner: On the basis of examination se Practioner: To the best of my	and/or investi	gation, in my opinior	n, death occurred at	the time, date and place	ce, and due to the o	cause(s) and manner stated.
Pot Veith	000		29b. Signature and title of certifier	Te.		29c, License			Date signed (Month	n, Day, Year)
	2		30. Name and address of person who of	completed cause of death (Item	23a) (Type, Pr) Han	mmels	Engl	PL 2	122)
Re	State egistra	-	31. Date filed (<i>Month, Day, Year</i>) SEP 2 2 2010	2. Registrar's Signat	par par	Ke !				

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	Please Type or Print in Black Indelible Ink, Ensure AMEND ITEM# 5 perf H, G908, 10/5/2010, William State of Maryland / Department of Health and Certificate of Death								aria ii	Reg. No. 2010 29713					13				
Dhy	cioio	n/	1. Decedent's Name											2. Date of Do	eath	112	Year	3. Time of De	eath
N	Physician/ Medical Bernard Edward Wheeler									·	_			Sept.	\neg		010	6:301	<u>М</u>
Exa	amin	٠.	13407 Jarrettsville Road Pi							Ph	oeni					Bal	of Death tim	ore	
Fund Direct			5. Social Security N 57030 212-26-5039 6. Sex 1 X M 2 G F 81						st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di Jan. 18	ay, Year)	Year) Country)			
and show	at	. 1	Usual Residence of D 10a. State	Decedent 10b. County				10c. City,	Town or Lo	cation								10d. Inside City I	Limits
Maryla 28a-f	otified	Director	Maryland	Baltin	ore .			Phœ	nix									1 🗌 Yes 2	XXNo
with the	ust be no	Funeral D	10e. Street and Numi 13407 Ja		tsvil	lle	Roa	ad		10f. Zip	Code 131					itizen of V			
altimore, Maryland 21215-0036 nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland nartment of Heath and Mental hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-1 show	Examiner m	ا۾	11. Marital Status 1	ed 2 X Man	ried 1	Vas Dece rmed Fo Ves Yes, Giv ear or Da	rces? 2 1	ver in U.S. No	'	Was Deced f Yes, spec	ify Cubar	n, Mexicar	n, Puerto	cify Yes or No Rican, etc.)		Blac	e - Ameri k, White, Wh		
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ylanc Ild be file Mental Hearked o	atic eve	100	Joseph A	lbert	Wheel									e (First, Middle Colgan	, Maiden	Surname			
Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental hygiene. important: If Item 27 is marked other than "natural", o	ner traum		19a. Informant's Nan Cynthia W			int) pous	se)		19b. Mailir 13407	ng Address 7 Jari	(Street a	nd Numbe svill	er or Rura .e Ro	ad Pho	er, City o ceni :	r Town, S X, Ma	tate, Zip aryla	and 2113	1
Baltimore, permit. Page 1 and Department of Hea Important: If item	ury or oth		20a. Method of Dispo 1 ☐ Burial 2 🔀 4 ☐ Donation	sition Cremation 5 🏻 Other (S	3 Remo	oval from	State	20b. Pla ce. Evan	ace of Dispo metery, cren S Fune r	sition (Nam natory or or al Cha Pel A	ther place rel	⁹⁾		20 , 2010				own, State l, Maryl	land
Baltimo permit. Page Department (Important: If	any inju		21. Signature of Fund			Λ			22	. Name an	d Addres	s of Facilit	Cha	pel & (Crem	ation	ı Sei	vices	4
Here			23a. Part 1. Enter the shock, or heart Immediate Cause (Fi	e disease, or failure. List d inal	complicationly one cau					er the mode	of dying	, such as	cardiac o	r respiratory a	rrest,	e, ™ e	H.Y	Approximate Interval Betwee Onset and Dea	en
Priysici Medi Exami	ical		disease or condition resulting in death)		C a. –			conseque	ence of):	E 15	sin	7				3	4	72cg	۲.
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funcial Director, falter this certificate has been signed by the attending physic completed filled in by the financial director man 2 shouly about the detached for use as the him.	0.000		F FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 9 Unknown	onths?	1 4	Live	Birth 2 nant at	of pregnand 2 Fetal time of de	death 3	Ectopic p Other (sp		/			ı	23d. Dat Mor		ery Day Yea	r
es that the signed by the detach	חבומ	≦	Part II. Other signific	ant condition	ns contribu	ting to de	eath bu	not resul	ting in the u	nderlying o	ause give	en in Part	1.					he cause of deat	
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VITAL RECO Sician: The law r certificate has b	aye 2	e l												auto perf	psy ormed?	p	rior to co leath?	mpletion of caus	
ian: T ian: T ian: T ian: T	100		25. Was case referred examiner?		I						26. Pla	ce of Dea	th (Check		2 DA'N	10] 1	⊔ Yes	2/C No	
· Vit hysic his ce		<u>۵</u>	1 🗆 Yes 2 🗀	No	Hospit	1 🗆			R/Outpatien	t 3 🗆 DC	Othe	r: 4 🗆 No	ursing Ho	me 5 AResi	dence	6 🗌 Othe	r (Specif))	
on of ending P eath. or, After t		Certificate:	2 Accident	5 Pendin	g jation	Ba. Date of the control of the contr	of injury h, <i>Day</i> ,		8b. Time of injury	M 28	Bc. Injury work?		. 1	28d. Describe	how inju	ry occurre	d		
Division of Vital Records, tal or Attending Physician: The law requires after death. The law conflicte has been signal Director. After this certificate has been signal in the functor factor range 3 chould he			3 Suicide 4 Homicide	6 Could r		e. Place buildir	of Injur ng, etc.	y - At hom (Specify)	ie, farm, stre	et, factory,	office		1	28f. Location (City or To			r or Rura	Route Number,	
ne Hospif in 24 hou e Funera		Medical	(Check 2 L	■ Medical E	xaminer: O	the bas	is of exa	amination a	and/or invest	igation, in n	ny opinior	n, death oc	curred at	d due to the ca the time, date e, and due to the	and place	e, and due	to the ca	use(s) and manne	er stated.
To the			29b. Signature and tit	le of certifier	Ran	she	69	n n	20		License	number	08		29d. Da	ate signed	(Month,		
WX		3	80. Name and addres	s of person v	vho comple	ted caus	e of de	ath (Item 2	3a) (Type, P	rint)	RI), Si	we 3	3 Lux		m	21	047	
	State	3	1. Date filed (Month)	2 201	0 /	32-8	nistrar	's natu	gar			-		`					

Alisha Wright	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death	Reg. No. 2010 29714						
Physician/ Medical Examine	(1. Decedent's Name (First, Middle,Last) 2. Date of Month	Death 3. Time of Death						
Jujedicai Examine	4a. Facility Name (if not institution, give street and number) A lisha Wright Septel 4b. City, Town, or Location of Death	mber 10, 2010 1511 hrs 4c. County of Death						
	Johns Hopkins Bayview Baltimore City							
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYYY) 9. Birth (MM/DD/YYYY) 9. Birth (MM/DD/YYYY) 9. Birth (MM/DD/YYYY) 9. Birth (MM/DD/YYYYY) 9. Birth (MM/							
ų	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits						
d tow any	MD Balto Catonsville	1 Yes 2 X No						
the Maryland a or 28a-f show tified at once.	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?						
ith the M s 23a or 2 to 10 to		U S A						
sr death with , or items 23 r must be no Funeral	1 Never Married 2 Married 2 No 11 Yes 2 No	.) White, etc.						
rs after ural", miner		Specify: Black 16b. Kind of Business/Industry						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatite event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4 or 5+) Bachelor College (1-4 or 5+) Bachelor							
5-00 filed win Hygier I other the M								
121 Id be fi Aental I narked event,		ntry						
AD 21 2 should h and Me 27 is ma matic ev	Verna Gentry-Mother 3126 Kenyon Avenue Ba	alto, MD 21213						
Baltimore, MD 21215-0036 oemit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than nijury or other traumatit event, the Medica	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition (Name of cemetery, crematory or other place)	20c. Location - City or Town, State						
imo Pages nent ol ant: I	4 Donation 5 Other Specify: Greenmount 9-18-20	Dlo Balto, MD						
Balt permit. Departi Import injury		East F/H						
Physician	23a. Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator	y arrest, shock, or heart Approximate Interval						
/Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. Cardiac arrhythmia	Between Onset and Death						
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.							
iner	if any, leading to immediate Due to (or as a consequence of):							
red unsit	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):							
0, e be executed rsician and burial - transit	W AMENDED 23a, PII, 27, per ME g908 10/21/10 TT per FH G97/ 9/24/10 TT							
Division of Vital Records, P.O. Box 68760 tal or Attending Physician: The law requires that the death certificate I as after death. 12 Director: After this certificate has been signed by the attending physical in by the funeral director, page 2 should be detached for use as the by artification: To Be Completed by Physician/Me		23d. Date of delivery Month Day Year						
Box e death the atte ed for u	1 Yes 2 No 9 V Unknown 9 Unknown	-						
rices that the signed by 1 be detached by Pl	Hyportongian: Obacity	Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown						
rds, require been si hould th	24a V	Was an 24b. Were autopsy findings available prior to completion of cause of						
Vital Records, sysician: The law requires in sentificate has been significate, page 2 should be o Be Completed	11-	death? ver 2 No 1 Yes 2 No						
ital Recition: The secrificate rector, page	25. Was case referred to medical examiner?							
n of Virding Physical After this funeral dir	7 Mayor of Double	Residence 6 Other:						
On C ending sath. or: Af the fun	1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No							
Division o spital or Attending nours after death filled in by the fine Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Tov	on (Street and Number or Rural Route Number, City vn, State)						
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the beneficial Certification: To Be Completed by Physician/Medical Certification:								
To wit	and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)						
	Allen Brassel, MD O.C.M.E.	September 11, 2010						
01.00	30. Name an address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
State								
Registrar								

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Year Physician/ Month SEP. ам ALLEEN O. WRIGHT 18 0937 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HOLY CROSS HOSPITAL MONTGOMERY SILVER SPRING Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) 8. Date of Birth Funeral 1 □ M 2**X**XF Days Hours Min. BUFFALO, NY **Director** 091.12.7472 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c, City, Town or Location Director 1 Ves 2 No MD PRINCE GEORGES SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3160 GRACEFIELD ROAD 20904 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc ò Completed by 1 Never Married 2 XX Married ☐ Yes 2XX No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√ No Specify: Specify. 3 Divorced 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. OFFICE CLERK NY TELEPHONE CP. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည STUART CUDLIPP EDITH PONTING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 DAVID M. WRIGHT SON 20868 WATERBEACH PLACE, STERLING, VA item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Donation 5 Other (Specify) ELMLAWN CEMETERY , INC. SEP. 25, 2010 TONAWANDA TWP., NY 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. ure of Funeral Service License REGOR FINK M01148 426 CRAIN HWY. S., GLEN BURNIE, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart fa tyre. List only one cause on each line.

SEED TO SEE 23a. Part Approximate Interval Between Onset and Death Immediate use (Final disease or condition Physician/ HEMORRHAGIC STROKE Medical resulting in death) Examiner MYOCARDIAL INFARCTION 2 wks Sequentially list conditions, if any tracing to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events tranand Due to (or as a consequence of): resulting in death) Last burial attending physician Physician/Medical Box 68760 as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death esn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 XXNo for Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown cate has been signed by the page 2 should be detached 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably 4 Unknown HYPERTENSION, HYPERLIPIDEMIA, DEMENTIA 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2XX No 25. Was case referred to medical examiner? **Division of Vital** the funeral director, 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes မ 2 XXNo XX Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Hospital or Attending Pl 24 hours after death. Funeral Director: After the Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural injury work? 1 ☐ Yes 2 ☐ No 5 Pendina Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who complete

BARBARA SUPANICH

31. Date filed (Month, Day, Year)

SEP 2 2 2010

DHMH 17 Rev 7/2009

RSM MD

HOLY CROSS HOSPITAL

ed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D 0065485

9/18/2010

1500 FOREST GLEN RD. SILVER SPRING, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sep ROIC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death <u> Karkville</u> enter timore are 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months 860 Hours Min. Country) 807 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified MD 1 🗌 Yes 2 🕱 No Himore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral nited 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 M Widowed 4 □ Divorced Mite Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ laranda SIMIC eraeda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) rard mD 21120 arkton 20b. Place of Disposition (Name of cemetery, crematory or other place)

And Cremation Services 9-18-2010 Forest Hill 20a. Method of Disposition ☐ Burial 2 🗹 Cremation 3 🗍 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Evan 3 Funerou Chapel + Cremation Services
[6924 York Road, Monkton, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Hyperlensive Cardiovascular Disease disease or condition resulting in death) Medical ue to (or as a consequence of Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due tá for as a consecuence offi To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Afibb, Alzheimers Disease Division of Vital Records. 1 Tes No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 R171944 Carl MSN ompleted cause of death (Item 23a) (Type, Print) Michealle G. Harrison BBCO Walther Blvd. Packville. were my 31. Date filed (Month, Day, Year) SEP 2 2 2010 State

Registrar

URSIS, VERONICA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4105 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Johns Hopkins Barriew Medical MW 8. Date of Birth (Month, Day, Year) 01/04/1919 **Funeral** Age (In vrs. last hirthday If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Hours **Director** 578-12-4255 Maryland Usual Residence of Decede 10a. State 10b. County items 23a or 28a-t sno ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maruland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3330 Gleneagles Drive. #68-20 20906 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Yes 2 X No Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No "natural" Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Senior Administrative Manager Department of the Navy other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Daniel Jenkes Manton Grace Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Sherron Couldren - Daughter 18809 Still Meadows Ct... Gaithersburg, MD 20879 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 X Burial 2 Cremation 3 Removal from State permit. Page Department or Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cem! 09/03/2010 | Adelphi, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring. 23a. Part 1. 5 her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ mau Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): burial-t attending physician I for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death the Unknown 9 Unknown P.O. ģ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an has after death.

Director: After this certification by the funeral director, 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Hospital: 2 🛮 No Other: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred Hospital or Attending injury Natural 5 Pending Division Investigation 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours af

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) Circle, Baltimore 10 Barriew

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Carolun H. Ahrens 9:13 am September 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery Sunrise Assisted Living of Silver Spr Silver Spring 7. Age (In yrs. last birthdav) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 1 □ M 2 🕱 F Days Vashington. Director 216-46-9350 DC Usual Residence of Decedent 28a-f show 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d, Inside City Limits Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11621 New Hampshire Avenue 20904 u.s.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 No Yes, Give 1 Never Married 2 Married <u>\$</u> 1 ☐ Yes 2 X No Specify. "natural", Specify: Completed 3 X Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Elementary School Teacher Education 4 Be Juid be file out and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Henry Helmers Annie Lee Wager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sl of Health a item 27 is 12818 Lacy Drive. Silver Spring. Maryland 20904 <u>Shawn C. Stringer</u> -Personal 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 s Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 09/09/2010 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Signature of Funeral Service Licensee HO#1070 <u> 11800 New Hampshire Ave., Silver Spring,</u> 23a. Part 1. Enter the stream, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fail ve. List only one cause on each line. Approximate Interval Between Onset and Death Years Imme istantise (Final Physician/ <u> Atherosclerotic Cardiovascular Disease</u> disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Exami transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician s the burial Physician/Medical that the death certificate be nding IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 X No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Retinal Melanoma Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Failure to Thrive 24a. Was an autopsy age performed? Yes 2 X No te Dementia Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificated filled in by the funeral director, it Be 25. Was case referred to medical 26. Place of Death (Check only one) Assisted Hospital 1 Yes 2 X No ြု 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural work? 5 Pending 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined completed filled in 24 hours a Funeral L Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

68760 Box (P.O. Records, Division of Vital

Baltimore, Maryland 21215-0036

12

To the l within 2 To the F

only one

29b. Signature and title of certifier

<u>Shyamsundar Rajan</u>,

IOW

8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD.

Registrar

State

9801 Georgia Avenue,

29c. License number

D53367

September 07, 2010

Suite 117, Silver Spring, MD 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29 Day Physician/ Month 9:10 pm David Irving Allentuck August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4928 Sentinel Drive, Bethesda #203 Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Days Hours Min. Month, Day, Y July 02 Massachusetts Director 577-48-2087 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 4928 Sentinel Drive. #203 20816 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' Black. White, etc. Completed by 1 Never Married 2 X Married 1 Yes ... If Yes, Give 2 X No Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 Divorced White. Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Owner/Operator Silkscreening Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Aaron Allentuck Jessie Friedman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elliott Allentuck - Son 2411 Chilham Place. Potomac. Maryland 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Grdns 09/01/2010 | Falls Church, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. neMarie 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition Wooks Medical resulting in death) Due to (or as a consequence of) Examiner Aortic Stenosis 3 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? Day Year Pregnant at time of death 2 No the page 2 should be detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Abdominal Aortic Aneurism 1 Tes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Bladder Cancer 24a. Was an After this certificate has autopsy performed?

1 Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🕱 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending injury 1 Yes 2 No ☐ Accident neral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I Confrying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier

10

DHMH 17 Rev 7/2009

State Registrar sconsin Avenue,

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5530

Wi

MD,

Gary Fisher.

D13818

Suite 700, Chevy Chase, Maryland 20815

August 30. 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Sept 2010 Bestor Tartt Bell 1:00 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Friends Nursing Home Sandy Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Alabama 1 XM 2 - F Months Days Hours Min 0471771915 Director 416-16-1520 95 Herral Residence of Decedent 28a-f show 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 XNo MD Montgomery Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17340 Ouaker Lane 20860 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after "natural", 1 ☐ Yes 2 X No Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) American Friends Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than " College (1-4 or 5+) Elementary/Seconday (0-12) Director Service Committee Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Renfro Bell Gertrude Tartt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald H. Bell/Son PO Box 1474 Rockaway Beach, OR 97136 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Cremation Svc. 9-8-2010 20a Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of P Important: If ite 1 Burial 2 X Cremation 3 Removal from State Hanover, MD injury (4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Accedent Corchro Una lAR Physician/ disease or condition resulting in death) MCAYS Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or iinjury the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ signed by the atte in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Vear Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by phechitis 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

Yes 2X No page death? certificate 1 Yes 2 No Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical Be funeral director, 26. Place of Death (Check only one) 1 ☐ Yes 2 🛣 No Other: ြုင 1 Inpatient 2 I BR/Outpatient 3 □ DOA 4 XNursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

10

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

State

Registrar

29b. Signature and title of certifie

ARTHUR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SCHOENGOLD

egistrar's Signature

Courses.

29c. License number

018726

18111 Prince Philypor, OLNEY

29d. Date signed (Month, Day, Year)

Sept. 8, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of M	laryland	,			id Mental Hy			00701	
			Registrar 1. Decedent's Name (First, Middle, L.	ast)		Cer	tificate of	Death	2. Date of De	Reg. No.		3. Time of Death	
	Physicia		1	Bergeron,	Jr.					er 10,	2010	12:00 PM	
	Medic Examin		4a. Facility Name (if not institution, gir			-	4b. City, Town, o	r Location of D			ty of Death		
1			Morningside Hou	se			Wald			Cha	arles		
	Funeral				ge (In yrs. last		If Under 1 Year Months Days		Hrs. 8. Date of Bir Min. (Month, Da	th v. Year)	9. Birth	place (State or Foreign	
	Director		230-22-3003	1 🛣 M 2 □ F	84	Yrs.		1.100.10	06/30	1926	Nort	h Carolina	
	nd how	5	Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Loc	ation					10d. Inside City Limits	
	faryla Ba-f s tified	ect	Maryland Charl	es	Wa1	dorf						1 ☐ Yes 🏋 No	
	the N	Ϊ́Ο	10e. Street and Number	-			10f. Zip Code			10g. Citizen of	What Cou	ntry?	
	s 23g	Funeral Director	70 Village St.				20602			USA			
	death item ner n		11. Marital Status	12. Was Decedent Armed Forces? 1 X Yes 2	Ever in U.S.	13. V	Vas Decedent of I Yes, specify Cub	lispanic Originí an, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)		ace - Ameriack, White,		
36	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	d by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 🕰 Yes 2 L If Yes, Give Year or Dates.	No	1	☐ Yes 2 🛣 No	Specify:			y: Whi		
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2	ygieng ygieng her th			6		Tea	cher			<u>!</u>	ation		
Maryland 21215-0036	e filec ntal H ed ot even	To Be	17. Father's Name (First, Middle, Last						Name (First, Middle,	Maiden Surnan	ne)		
Š	ould b d Mer mark matic	-	Hubert Bunn Ber 19a. Informant's Name/Relationship		-	40- 14-11-		<u> </u>	Howard	City on Town	Ctata Zin	Carlo	
¥a	2 shoth the shot		James A. Palmer,						r Rural Route Numbe Indian_He	-			
Ē,	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tra once.		20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Name of		Date	20c. Location			
E	Page nent o ant: If ant: If ury or		1 ☐ Burial 2 X Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from State cify)	⁷		natory or other pla $\mathbf{d} extbf{-}\mathbf{Echols}$	· :	9/11/2010	Charlo	tte H	all. MD	
Baltimore,	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Lice	nsve		22	. Name and Addre	ess of FacilityB	rinsfield	-Echols	Fune	ral Home	
_	82789		Hayter C. Co	hart	M0081	100					Hall	, MD 20622	
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that cause one cause on each lin	ie.	4)			rest,		Approximate Interval Between	
a	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a CAN	CHENS		(ROST					Onset and Death	
1	Examiner		resulting in death)	Due to (or as	a consequer	nce off:	ATILE	00 60	Land	7.7			
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequer	nce of):	1 21 142	100 30	<u></u>				
	ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events										
	exect an an rial-tr	Ĕ	resulting in death) Last	Due to (or as	a consequer	nce of):							
200	cate be executed physician and the burial-transit	edical		d									
687	ertifica ling p e as t	/Me	IF FEMALE:	23c. If yes, outcome	of pregnance	**/							
Box (ath certific attending p	cian	23b. Was decedent pregnant in the past 12 months?		2 Fetal d	death 3	Ectopic pregnar Other (specify)	су			23d. Date of delivery Month Day Year		
Ω.	that the dealed by the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 🗌 Unknown	at time of dec								
P.O.	that the ned by deta		Part II. Other significant conditions	contributing to death	but not result	ing in the u	nderlying cause g	iven in Part I.	23e. Did t	obacco use cor	ntribute to t	the cause of death?	
ds,	requires t been sign should be	Completed by	***						_ 1□	Yes 2 □ No	3 🗌 Pro	obably 4 Unknown	
Ö	aw req as bee 2 sho	plet	1						24a. Was		. Were auto	opsy findings available ompletion of cause of	
Rec	sician: The la certificate ha irector, page 2	E O							_ perfo	ormed? 2 tv No	death?	2 🗀 No	
<u>e</u>	sian: ertific ctor,	Be (25. Was case referred to medical examiner?	Lleawitel.					Check only one)				
<u> </u>	Physic this ce	မ	1 Yes 2 XNo 27. Manner of Death		tient 2 EF	R/Outpatier		4 L Nursi	ng Home 5 Resi			wed Living	
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Sio	r Attencer death rector: / by the	rifi	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of In	jury - At home	e, farm, stre	eet, factory, office	103 2 110		Street and Num.	ber or Rura	al Route Number,	
Division of Vital Records,	al or / s after il Dire		4 🗆 Hornicide — determine	building, et	tc. (Specify)				City or To				
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Pr (Check 2 Medical Exa	nysician: To the best of	f my knowled	lge, death o	occured at the tim	e, date and pla	ce, and due to the ca	ause(s) and man	ner as stat	ed. ause(s) and manner stated.	
	the H thin 24 the Fi	Me	only one) 3 Certifying Nu	irse Practioner: To the			leath occurred at t	ne time, date an		ne cause(s) and r	manner as s	stated.	
	5 5 5 00		29b. Signature and title of certifier	1	(M	29c. Licens	se number	74	29d. Date sign	ed (Month,	Day, Year)	
	1			June	death (14 - 17 %)	TO IV	- L	106	50/	1	1	-108	
T)		30. Name and address of persol who	completed cause of c	TTL-	Yan '	NM	WA	LDOW	(, M	· b.	20103	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registi	rar's Signatur	e A	1.11	- 0.		,			

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of Maryland / D		rtment of H ificate of D					
		Registrar 1. Decedent's Name (First, Middle, Las		0011	medic or B	- Cutin	2. Date of De		10	9-Time of Death
Physicia Medic		William Adrian					Septeml	per 11,	2010	10:20AM
Examin	er	4a. Facility Name (if not institution, give 38345 Pleasant V	'		4b. City, Town, or I Charlott		4c. Count	3		
Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birth	nday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	:h	9. Birthpl	lace (State or Foreign
Director		217-32-0708 1 Usual Residence of Decedent	X ^{M 2 □ F} 74	Yrs.	IVIOITITIS Days	Tiodis IVIII.	107247	1935	Mary	ľánd
and show d at	ē	10a. State 10b. County	10c. City, Town	or Loca	ation				10	0d. Inside City Limits
Mary 28a-f notifie	irec	Maryland St. Man	y's Charl	Lott	e Hall					1 Yes 2 XNo
vith the 23a or st be r	Funeral Director	10e. Street and Number 38345 Pleasant Vi	lew Drive		10f. Zip Code 20622			10g. Citizen of United		
leath v items ier mu	Fun	11. Marital Status	12. Was Decedent Ever in U.S.		as Decedent of His Yes, specify Cuban				ice - America	
after c	d b	1 Never Married 2 Married 3 Widowed 4 X Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give		Yes 2 X No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specif	ack, White, e fy: W }	nite
hours	ete	15. Decedent's E		Decede	ent's Usual Occupa nd of work done du	tion		16b. Kind of I		
21215-0036 within 72 hours after glene. er than "natural", o er, the Medical Exam	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)		NOT use retired)	ining most of work	ng	Farm e	สมรักพะ	ent
led wit Hygie other ent, th	Be	17. Father's Name (First, Middle, Last)	1:	lalla		18. Mother's Nam	e (First, Middle,			
Vian d be fi Mental arked artic ev	유	Adrian N. Bridget	:t			Clara E	. Ching	_		
'e, Maryland 21215-0036 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show wither traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (7) William Bridgett/		Mailing 463	Green Ga	bles Ct.	n Route Numbe Mecha	r, City or Town, nicsvil	State, Zip C 1e, MI	ode) 0 20659
F - F - C		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Populition 5 □ Other (Specif	Removal from State cemeter	v. crema	ition (Name of atory or other place morial G) i	Date -17-201	20c. Location	-	wn, State Maryland
Baltimo permit. Page Department of Important: If any injury or once.		21. Signatury of Funeral Savia Licens	y/	22.	Name and Address	s of Facility Br	insfiel	d-Echol	s F.H.	., P.A.,
		23a. Part 1. Enter ne disease, or com	plications that caused the death. Do no						Hall.	MD 20622 Approximate
Physician/		shock, or heart failure. List only o Immediate Cause (Final disease or condition	Terminal	e	3(0.7	· lun	01		1	Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as a consequence o	f):	D. Til)			
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of	4)@	faller)				
certificate be executed certificate be executed nding physician and use as the burial-transit	Examiner	Cause (Disease or iinjury that initiated events c. Due to (or as a consequence of):								
ate be e	edical	•	d							
68/ certifica ding p	_/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy					23d. D	ate of delive	erv
ords, P.O. Box 68, verying the death certification is the attending should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)					Day Year
that the ned by the detaching		g ☐ Unknown Part II. Other significant conditions or		n the un	derlying cause give	en in Part I.	23e. Did t	obacco use cor	ntribute to th	ne cause of death?
uires th	ed by					<u>-:</u>	1 🗹	Yes 2 ☐ No	3 🗌 Prot	oably 4 🗌 Unknown
VITAI HECONTS, P.O. BOX ysician: The law requires that the death is certificate has been signed by the atte director, page 2 should be detached for	Completed						24a. Was auto	psy	prior to cor	psy findings available mpletion of cause of
The I		25. Was case referred to redical			00 Pk	CDII- (Ob	1 Yes	2 No	death?	2 🗋 No
VITA ysiciar s certif	To Be	examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	tpatient	Other	ce of Death <i>(Chec</i> r: 4 Nursing Ho		dence 6 ☐ Ot	her (Specify)
n of ding Phy th. After this funeral d		27. Manner eath 1 Latural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Ti		28c. Injury work?	at		now injury occu		
DIVISION OT tal or Attending Pi rs after death. al Director. After the ed in by the funera	Certificate:	3 Suicide 6 Could not b		m, stree	et, factory, office		28f, Location (S City or Tox		ber or Rural	Route Number,
Division of Vital Hecc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 is	Medical	(Check 2 Medical Exam	sician: To the best of my knowledge, of iner: On the basis of examination and/or	r investi	gation, in my opinior	n, death occurred a	t the time, date a	and place, and d	lue to the cau	use(s) and manner stated.
To the within ? To the somple	Š	only one) 3 Certifying Nurs	se Practioner: To the best of my knowle	edge, de	eath occurred at the 29c. License		ce, and due to the	e cause(s) and r 29d. Date sign		
		Keeumar	ce youda	Y);	DI	7168		9/13	110	
.]		30. Name and address of person who								
Stat	e	31. Date filed (Month, Day Year) 4	Zazdani, Huntingto 2010 32. Rigistrar's Signature J.	JWII,	IND SOLVER					
Registra	r	2EP 14	culy serous p.	19	4000					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12, Victor Michael: Bauer 2010 September 5:38 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 6580 Dobbins Ct. La Plata Charles 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours Min. 1 ₹ M 2 □ F 398-07-6389 90 Director Feb. 5, 1920 Wisconsin Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show event, the Medical Expressions and be notified at Director 1 ☐ Yes 2 XNo Maryland Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 6580 Dobbins Ct. 23a 20646 United States Funeral death or items Was Decedent Ever in U.S. Armed Forces?
 1 XYes 2 ☐ No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or item any Injury or other traumatic event. Its intermediate proces. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 X No ğ If Yes, Give Year or Dates Specify Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Painter Painting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Bauer Anna Ruhland ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki Rehm/daughter 6580 Dobbins Ct., La Plata, MD 20646 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 9/14/2010 Brinsfield-Echols Crem. Charlotte Hall, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Funeral Service Licensee M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear timilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 6 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): burial-transi and resulting in death) Last Due to (or as a consequence of): attending physician by Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed should has been 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy death? 1 ☐ Yes perform certificate 1 ☐Yes 2 NO 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this nours after death.

neral Director: After this

filled in by the funeral d 27. Manner of Dear 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Box 68760. P.0. Division of Vital Records,

Hospital 24 hours a To the within 2

State

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifie

Medical

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State o	of Maryland		artment of H		Mental Hy	giene	0.1.0	00701		
		Registrar		<u> </u>	Cer	tificate of D	Death	1	Reg. No.	2010	29124		
Physicia	an/	1. Decedent's Name (First, Middle	. ,	n - 1	0			2. Date of De Month Septem		Year	3. Time of Death		
Medic		Paul F 4a. Facility Name (if not institution	rancis	Baden,	Sr.	4b City Town or	Location of Death			3, 2010 County of Death			
Examir	iei	16301 Croom R				Brandyw					ince George's		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		rth	9. Birth	place (State or Foreign		
Director		216-30-2747	1 🕅 M 2 🗆 F	76	Yrs.	Months Days	Hours Will.	(Month, Da 04/28	/1934	Cou	Maryland		
nd how at	٦	Usual Residence of Decedent 10a. State 10b. County	,	10c. City,	Town or Loc	ation	-				10d. Inside City Limits		
faryla 8a-f s tified	Director	 Maryland Princ	re George'	s Bi	randyw	ine					1 🗆 Yes 2 🙀 No		
the Na or 2	٥	10e. Street and Number	ce dearge	<u> </u>	z diray	10f. Zip Code			10g. Citize	en of What Cou	intry?		
h with 1s 23a nust I	Funeral	16301 Croom F	Road			20613	3		U	S A			
r item		11. Marital Status	Armed Fo			Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	- 14	 Race - Ameri Black, White 			
urs after tural", o	d by	1 ☐ Never Married 2 🔀 Mar 3 ☐ Widowed 4 ☐ Divorced	If You Give		1	☐ Yes 2 🗷 No	Specify:		S	pecify: Wh	ite		
hours natur	Completed	15. Decede	d of Business Ir	ndustry									
in 72 Te. han " e Med	omp	(Specify only higher Elementary/Seconday (0-12)											
d with dygier ther t	Be C	12	1 0			Mechanic					Trucks		
antal Figure (ed or	To E	17. Father's Name (First, Middle, I George R.	Baden,	Sr.			18. Mother's Nar Margar	_		rname) Tayman			
ould I		19a. Informant's Name/Relations		DI.	19b. Mailin	g Address (Street a					Code)		
Mic d 2 sh alth a alth a 27 is r trau		Carolyn Baden/				Croom R					ocus,		
of Her of Her fitem		20a. Method of Disposition	-		ace of Dispos	sition (Name of natory or other plac	!	Date		ation - City or T	own, State		
Page ment ant: h		1 🛣 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		Otato		Memorial		8/2010	Wa1	dorf, M	D		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service I	Licensee		22 B	Name and Address rinsfield 0195 Thre	es of Facility	Funeral	l Home	P.A.	1, MD 20622		
		23a. Part 1. Enter the disease, or shock, or heart failure. List of								LE Hal	Approximate		
Ph sician/		Immediate Cause (Final disease or condition	•	Acute Le	ukemia	3					Onset and Death months		
Medical Examiner		resulting in death)		or as a conseque									
	er	Sequentially list conditions	D	Polycyth or as a conseque		/era					3 years		
ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Bus to t	or as a conseque	silee oij.								
execur in and ial-tra	Exa	that initiated events resulting in death) Last	c Due to (or as a conseque	ence of):								
ate be executed physician and the burial-transit	dical		d										
rtifica ling pl	/Me	IF FEMALE:	00- 16										
ath certifica attending p	cian,	23b. Was decedent pregnant in the past 12 months?	1 Live	come of pregnan Birth 2 Fetal nant at time of de	death 3 [Ectopic pregnanc	у		23	3d. Date of deli- Month	very Day Year		
that the dested by the stached	Physician/Me	1 Yes 2 No 9 Unknown	9 🗆 Unkr		Salli OL	Other (Specify)							
Attending Physician: The law requires that the death certifica refeath certificate has been signed by the attending py the funeral director, page 2 should be detached for use as	by PI	Part II. Other significant condition	ons contributing to d	eath but not resu	Iting in the ur	nderlying cause giv	en in Part I.	23e. Did t	tobacco use	contribute to	the cause of death?		
v requires the speed signer should be								1 🗆	Yes 2	No 3 ☐ Pro	bably 4 \Unknown		
aw rec as bea 2 sho	Completed							24a. Was	DSV -	24b. Were auto	opsy findings available ompletion of cause of		
The la	Con							perfe 1 \square Yes	ormed? 2 No	death?	2 🗆 No		
sician: certific irector,	m	25. Was case referred to medical examiner?	Hospital:			26. Pla	ace of Death (Chec	ck only one)					
Phys	2	1 Yes 2 No 27. Mann of Death	28a. Date	Inpatient 2 E	R/Outpatien	t 3 DOA 28c. Injury	4 ☐ Nursing H	ome 5 Resi			y)		
ath. ath. :: Afte e fune	icate	1 Natural 5 Pendir Pendir Investi	ng (Mont	th, Day, Year)	injury	work	? Yes 2 □ No	Zod. Describe	now injury c	ocurred .			
Atter er dez ector by th	Certificate:	3 Suicide 6 Could determ	not be 28e. Place	of Injury - At honing, etc. (Specify)	ne, farm, stre	et, factory, office				Number or Rura	al Route Number,		
ital or rrs aft ral Dir			il.					City or To			9		
To the Hospital or Attending Physicial 24 hours after death. To the Funeral Director. After the completed filled in by the funeral	Medical	(Check 2 L Medical E	g Physician: To the b Examiner: On the bas g Nurse Practioner:	is of examination	and/or investi	gation, in my opinio	n, death occurred a	at the time, date	and place, a	nd due to the ca	ause(s) and manner stated.		
To the within 2 To the comple		29b. Signature and title of certifier	A .		^	29c. License				signed (Month,			
		Milloly A	Della	cian Mi	<u>) </u>	D 64	1234		09/	15/2010)		
de		30. Name and address of person Nicholas DeMo	who completed caus										
		Nicholas Deno	naco	Woo	odyard	Road, Cl	linton, N	1D 20735)				
Stat Registra		31. Date filed (Month, Day, Year)		Woo egistrar's Signatu			linton, N	4D 20735		<u> </u>			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 РМ Beverly T. Burton August 9:27 Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4677 Muddy Creek Rd. Galesville Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Apr 18 1958 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2**X** F 220-68-5632 52 Maryland Yrs Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Anne Arundel Galesville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4677 Muddy Creek Rd. 20765 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Epes Building & Elementary/Seconday (0-12) College (1-4 or 5+) 12th Maintenance n Project Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harold C. Turner Bessie M. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shenae Moulden(Daughter) 8138 Harold Ct. Glen Burnie, Md. 21061 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Memorial Park 9 - 3 - 10Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) Mame Register Scill Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. M308 a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ AWIE MYOCARDIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence oi). To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 X No 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è BBETES 1 Ses 2 No 3 Probably 4 Unknown cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy **Director:** After this certificate I 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) hours after within 24 hours a To the Funeral I Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar 29b. Signature a

STEPHEN

31. Date filed (Month.

title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			Plea	se Type or Pri						_		gible.		
			For	State of Ma	aryland				lealth and N	Mental Hy	giene			
			State Registrar			Cer	tificate	of L	Death		Reg. No. 2	110	29726	
	Physicia Medic		1. Decedent's Name (First, Middle, Orville Euge	ne Bailey						2. Date of Dea Month	3. Time of Death O/YSAM			
مرد	Examin	er	4a. Facility Name (if not institution, PENINSULA REGIO	1 1	e Ca	ntel	4b. City, T		Location of Death		4c. County of Death W. com I Co			
	Funeral Director		5. Social Security Number 214-30-9372	6. Sex 7. Age 1 X M 2 □ F	e (In yrs. last 78	t birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 2-25-19	v Year)	g. Birthplace (State or Foreign Country) Virginia		
	show dat	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation			10d. Inside City Limits				
	e Mary r 28a-1 notifie	Director	DE Susse	x	Lau	re1 10f. Zip Code 10g. Citizen of W							1 Yes 2X No	
	vith th	eral	9953 Willow Way				101. 2.10		956		USA	What Cou	muy:	
936	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:						14. Ra Bla	14. Race - American Indian, Black, White, etc. Specify: White			
2-0	hours natur	olete	15. Deceden (Specify only highes	t's Education		16a. Deced	ent's Usual	Occupa	ation during most of work	dpa	16b. Kind of I	Business Ir	ndustry	
21215-0036	filed within 72 al Hygiene. J other than '	Completed	Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use retired) 12 Disabled Disable									bled		
pu	be filed ental Hy rked oth ic event	To Be	17. Father's Name (First, Middle, La	Ť					18. Mother's Nam	,,		ne)		
Maryland	ould be fi d Menta marked matic ev		William Bailey		1	10h Mailin	a Addroso	(Stroot o		se Smith		State Zin	Cadal	
Z	1 and 2 should be if Health and Men item 27 is marke other traumatic	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 11 and 11 and 12 and 12 and 12 and 13 and 14 and 15 and 15 and 16											Gode)	
Baltimore,	of Hearlifitem		Judith Bailey (Wife) 9953 Willow Way Laurel, De. 19956 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - Cit										· ·	
ti m	permit. Page 1 Department of Important: If i any injury or once.		4 ☐ Donation 5 ☐ Other (S)	pecify)	Brit	tingh	Management	Adalasa					, Virginia	
Bal	permir Depar Impor any ir		21. Signature of Funeral Service Li	- 1		Ha	nniga	n,S	ss of Facility hort ,Dish	naroon F	.н. 700	West	Street De. 19956	
			23a. Part 1. Enter the disease, or a shock, or heart failure. List or	complications that cause	the death.	Do not ente	r the mode	of dying	g, such as cardiac	or respiratory an	rest,		Approximate Interval Between	
	Physician/ Medical	. 2	Immediate Cause (Final disease or condition resulting in death)	a	TO	olit	25,	re	eure	nt		_	Onset and Death	
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	d sit	niner	Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or iinjury	inter Underlying isease or linjury Let Underlying isease or linjury Christian Underlying isease 2-3 Tears								Ye. co		
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x 68760	death certificate be executed ne attending physician and ed for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic p	regnanc	ev		23d. D	ate of deliv	very	
. Box	ne death y the att ched for	nysici	in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown			Other (spe				M	onth	Day Year	
, P.O.	requires that the de been signed by the should be detached	d by P	Part II. Other significant condition	ns contributing to death b	ut not result	ting in the u	nderlying ca	ause giv	ven in Part I.	23e. Did to	. /		the cause of death?	
ords	Attending Physician: The law requires sroteath. sroteath. by the this certificate has been sign by the funeral director, page 2 should by	Completed by			·					24a. Was	an 24b	Were auto	opsy findings available	
3ec	sician: The law r certificate has k lirector, page 2 s	omo								autor perfo 1 Yes	rmed?	death?	ompletion of cause of	
tal	cian: T	Be	25. Was case referred to medical examiner?	Hospital:		26		1	ace of Death (Chec					
Ϋ́	Physi r this o rral dire	<u>∺</u> 10	1 Yes 2 No 27. Manner of Death	1 Inpatie		R/Outpatien 8b. Time of		A Othe	4 ☐ Nursing H	ome 5 Resid			ý)	
ou c	anding ath. rr. Afte	ficate	1 Natural 5 ☐ Pending 2 ☐ Accident Investig	ation	/, Year)	injury	М	work	? Yes 2 □ No					
Division of Vital Records,	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Certificate:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi			e, farm, stre	et, factory,	office			ation (Street and Number or Rural Route Number, or Town, State)			
_	e Hospita 24 hours e Funera leted fille	Medical	(Check 2 L Medical Ex	Physician: To the best of caminer: On the basis of ex Nurse Practioner: To the	xamination a	and/or invest	igation, in m	y opinio	on, death occurred a	at the time, date a	nd place, and d	ue to the ca	ause(s) and manner stated.	
	Vithin Comp	2	29b. Signature and title of certifier	0 /		anovirougo, a			e number		29d. Date sign			
Ţ	MM		20 Name and address of	undo fo	anth (Ham 2	- ju	nint) E	(nn	004/2	0.0	7/	5/1	٥ ا	
	INA		30. Name and address of person w	E. Carrollo	St/se	A J	Sal15!	bur	y Mai	y lane	Q 21	801		
	Sta		31. Date filed (Month Day Year)	2010 32. R histra	ar's Signatur	re /	here	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Amended item #8, per f.h., 9/8/10, E.T, Certificate of Death WCHD Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 9 2^{Day} 2010 9:20 A M Joan Crawford Bailey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Berlin Atlantic General Hospital 8. Date of Birth 8 10/1933 Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2 🛣 Hours Min. 77 PA 220-28-1029 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10d. Inside City Limits be filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location Director 1 Yes 2 XNo Ocean City MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 13056 Riggin Ridge Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: white Completed 3X Widowed 4 ☐ Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natuay injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mayme Lewis Unknown Truitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9213 Coastal Hwy., Ocean City, MD 21842 John Trader / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Other (Specify) Sunset Memorial Park | 9/6/2010 Berlin, MD Penation 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications at at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final conte Mya ardial Physician disease or condition resulting in death) Medical Due to (or as monsequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 4 Pregnant Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 🗌 Yes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Covanain After this certificate has autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work?
1 Yes 2 No 5 Pending Investigation filled in by the 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours and To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner To the best of my knowledge, detti 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

10445 and Ocean City Bud, #1, Berlin, MO 21811

D0066169

09/03/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Donald Harry Bennett 2010 Sept Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Calvert Memorial Hospital</u> Prince Frederick Calvert If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year)
2/3/1934 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🕅 M 2 🗆 F 76 Director 229-38-8393 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Calvert. MD Chesapeake Beach 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7603 Old Bayside Road 20732 IISA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates. 50 - 53 1 X Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", Specify: White 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Vending Machine 12 æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Bennett Helen Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Cox/Sister 2778 Pk. Sq. Pl., Fernandina Bch, FL 32034 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crem. 9/9/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Li 22. Name and Address of Facility Raymond-Wood F.H., P.A. our PO Box 430, Dunkirk, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician METASTATIC SAVENNUS CUIT disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-transi the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown signed by 1 d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ischemic Cardiomopathy or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown distruction due to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate It lett inquinal hern 1 Yes 2 No 25. Was case refe ed to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation completed filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd. Prince Frederick mp

State Registrar

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31. Date filed (Month, Day, Year)

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32. Registra

2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 2010 1429 FM September Kathy Chimera Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex **Funeral** (Month, Day, Year) Oct 14, 1934 Country) Hungary Min. **Director** 277-30-3653 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location or 28a-f shov 10a. State 10b. County death with the Maryland Director 1 Yes 2 XNo must be notified Silver Spring Maryland Montgomery 10g, Citizen of What Country? 10e. Street and Number Funeral items 23a United States 20906 3330 N. Leisure World Blvd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces ☐ Yes 2 ☐ No ٥, 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: If Yes, Give "natural" Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Ophthalmologist Secretary 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file
Department of Health and Mental I:
Important: If item 27 is marked of
any injury or other transcript မ Katherine Yilling Mokler Henry Chimera 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3330 N. Leisure World Blvd. #131 Silver Spring, MD Carmen Robert Chimera/husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 9/9/2010 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 re of Funeral Service Lice Domas M00957 23a. Part X Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death poglycemia Immediate Cause (Final Due to (or s a con-uence of) hours Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No page 2 should be detached for Pregnant at time of death 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 2 No this certificate has death? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certificate: To 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signate 05,2010 553 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, MD 20850 Medical Ctr. Dr. c Nei 9901 MD 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature, State 2010 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day A^{M} 8:05 2010 Clark Medical Nathaneil September 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospice House of St. Mary's Mary's Callaway Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days Hours 1 😿 M 2 □ F 34 Director 089-60-7759 06/15/1976 New Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🏋 No St. Mary's Maryland Mechanicsville 10e. Street and Number 10g. Citizen of What Country? Funeral 30185 Suite Landing Rd. 20659 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: "natural", Specify: White 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Field Service Representative Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Curtis Linda Diane Gage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Ann Curtis/Wife 30185 Suite Landing Rd, Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State 4 Donation 5 Other (Specify) 09/13/2010 | Charlotte Hall, MD Brinsfield-Echols 21. Signature of Funeral Service License 22. Name and Address of Facility Brinsfield-Echols Funeral Home M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ plexus disease or condition Medical resulting in death) Due to (or as a consquence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to roll as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes certificate has been si irector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsy performe 8 B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA After this Director: After this in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Division of Vital Records, P.O. Box 68760 within 24 hours are.

To the Funeral Dir

> State Registrar

only one) 29b. Signature and the

Jennifer Schmidt,

31. Date filed (Month, Day, Year)

30. Name and appears of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

32, Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

H0055751

40900 Merchant Lane, #205, Leonardtown, MD 20650

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:03A M Roland H. Carey, Jr. 2010 09 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospice the Lake lisbur 100 m 100 5. Social Security Number If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign MD ountry) 1 X M 2 □ F Days 213-22-2546 Hours Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 23a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Berlin 1 🗆 Yes 2 🖺 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10254 Carey Rd. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Yes, Give 21215-0036 Specify: white 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) clerk lumber company Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roland H. Carey, Sr. Anna Hastings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10254 Carey Rd. Berlin, MD 21811 (wife) Betty Carey 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evergreen Cemetery 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 9/5/2010 Berlin, MD 4 Donatio 21, Signatur f Fun 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, c only one cause on each line Immediate Cause (Fir disease or ondition Physician/ CBREBROVASCULAR Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, If any, heading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for the a consequence of Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Day Other (specify) Year 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2/ No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No Certificate: To HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) D0058410 30. Name and accress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Roland

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31. Date filed (Month, Day, Year)

1733 SACY BURG

My 21802

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Pregistrar ANO HEALTH DEPT CMH

Decedent's Name First Middle 1 = 21 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month hillip Collins 238 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death AnnaPolis, mD Anne ARUNDEL ARUNDEL MITDICAL CENTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days OCT. 24 Year 947 Maryland 217-46-4529 Director 62 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Davidsonville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3101 Beards Point Rd. 21035 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, rmed Forces? Black, White, etc. 1 Never Married 2 X Married <u>ک</u> Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1969 – 1 ☐ Yes 2 🔀 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 7 and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th 0 <u> Maintenance Supervisor</u> Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Phillip Thomas Collins Sr Ruth Randall Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21035 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Constance L. Collins(Wife) 3101 Beards Point Rd. Davidsonville, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Maryland Veteran 9 - 7 - 104 ☐ Donation 5 ☐ Other (Specify) Crownsville, Md. W Manne a Recorse con recility Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 M00483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Eno-StagE Physician/ RENAL DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner FAILURE TO THRIVE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events CLOSTRIDIUM DIFFICILE DIARRHEA and -transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IE FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CEREBROVASCULAR ACCIDENT Records, 1 Yes 2 No 3 Probably 4 Unknown PROSTATE CANCER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 1 Yes 2 No Yes 2 1 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death.

Director: Aff
d in by the fur 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 1 Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number Aprillanuer 165292 02,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIA VIllAnueva, md 2001 Medical Parkusy 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

68760

Box (

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Elizabeth Desimone September Beatrice 7:35 a.m. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Chesapeake Shores Lexington Park Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day une 12 1 □ M 2 🛛 F Months Days Hours Min Country Director 1923 225-12-4115 June Virginia Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🖾 No Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 23140 Cobblestone Lane, Apt. 112 20619 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 Yes 2 X No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Civil Service ibrary Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bessie Lena Turner Fitcher Lee Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry Desimone/Son 1005 England Drive, Stafford, VA 22554 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Immaculate Heart of Mary Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/15/2010 Lexington Park, MD Signature Funeral Service Liebee

Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 20650 Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due t (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury 03 that initiated events resulting in death) Last Due to (o) as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. **Other** si**gnificant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 3120DNOSE autopsy performed After this certificate 1 Yes 2 No Yes 2 Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) Hospital 1 Tes 2 🛮 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 🗌 No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 124 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or inventionable in musclinia death. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Moon 2016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 eme Youngsik Moon, M.D. 24435 Mervell Dean Road, Hollywood, MD 31. Date filed (Month, Day, Year) State Registrar's Signat SEP 13 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 2010 13:15 PM Laura Elizabeth Dean Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cecil Union Hospital of Cecil County **Elkton** Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country Cass West Virginia 8. Date of Birth **Funeral** 1 □ M 2**X** F Months Hours Min. (Month Day, Year) 31 Director 235-46-2619 79 Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No North East Maryland Cecil 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21901 United States 20 Cemetery Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2**XX**No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White Specify: 3 ₩Widowed 4 □ Divorced Completed Year or Dates. . Page 1 and 2 should be filed within 72 hours tment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur jury or other traumatic event, the Medica!.] 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government Nursing Aid Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Cassell Edna Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah L. Miller / Daughter 8 Old Elm Road, North East, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of North Figure 1992) St. Church Cemetery (1992) St. Church Cemetery 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If ii any injury or o 1 Burial 2 Cremation 3 Removal from 4 Donation 75 Other (epecify) September North East, Maryland 22. Name and Address of Facility Crouch Funeral Home 21. Signatur 127 South Main Street, North East, Maryland21901 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the diseas shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysiciani Unknown disease or condition resulting in death) Medical Tenkn wi Examiner Sequentially list conditions, if any leading to in reclict cause. Enter Underlying Cause (Disease or linjury Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown g Unknown To the Hospital or Attending Physician: The law requires man within 24 hours after death.

To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 \(\sum \) Yes 2 \(\overline{N} \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certife

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State Registrar

DHMH 17 Rev 7/2009

who completed cause of death (Item 23a) (Type, Print)
DEU MD, 186 A, E High ST, Elizan MD 21921.

9.7.2010 .

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32. Registrar's Signature

S. S SACHDEU MD,

31. Date filed (Month, Day, Year) **SEP 08 2010**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 1 2010 Jennifer Daniels August 0801 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Months Days Hours Feb 2 Bountay) Director 214-50-9766 61 1949 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits Direct Maryland Anne Arundel 1 Tes 2X No Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 604 Moonglow Rd. Apt 101 21113 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2X Married 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced Black. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Department of Elementary/Seconday (0-12) College (1-4 or 5+) 12th n Clerk Defense Be Department of Heath and Mental Hy.
Important: If item 27 is marked othe any injury or other trainment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Golatt Sarah Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Daniels(Husband) 604 Moonglow Rd. Apt 101 Odenton, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veteran 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 9-8-10 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Minimame Ranges of Macilii Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 23a. Fart 1. Ent the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. 21401 Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequen Examiner Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Year Day Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No ☐ Yes the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner eath Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Accident
2 Accident
3 Suicide
4 Homicide injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

29b. Signature

31. Date filed (Month,

who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistrarAmend#20b.PerFHPGC9-14-10cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 1 1:19 PM Cunningham Downing Jacqueline Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Regional Hospital Prince Laurel Laurei seorge 1 Year If Under 24 Hrs 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) if Under 8. Date of Birth **Funeral** 1 🗆 M 2 💢 F Months Hours Min. 5/211/1951 Manhattan, NY 59 **Director** 577-70-9321 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Washington, DC 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 2302 20018 13th Place, NE United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian. Armed Forces? 1 ☐ Yes 2 1 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2X No Specify: Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Social Worker D.C. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Prince Cunningham ည Henry Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tianeka Arno / Daughter 817 8th Street, NE, Wash, DC 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sept. 10,2010 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Lincoln Memorial Cem. 9/9/2010 Suitland, MD 21. Signa uneral Service Licensee 22. Name and Address of Facilit Pope Funeral Home URRI 2617 Pennsylvania Ave, SE, Wash, DC 20020 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year signed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy eral Director: After this certificate I filled in by the funeral director, page 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 M No 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 Tyes Investigation 6 Could not be 2 🗌 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier

State Registrar

and address of person who completed cause of death (Item 23a) (Type, Print)

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Examine

Physician/Medical

Be Completed by

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Certificate:

Medical

29a. Certifier

(Check

only one) 29b. Signature and title of certific

physician and the burial-transit

attending physician

signed by the a d be detached fi

cate has i

P.O.

Records,

use as

02-08-1927 Wash., D.C. 10d. Inside City Limits 1 Tes 2 No

10g. Citizen of What Country?

USA

2010

Anne Arundel

4c. County of Death

3. Time of Death

4:48

g. Birthplace (State or Foreign

РМ

20711 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

2. Date of Death

8. Date of Birth

September

14. Race - American Indian. Black, White, etc. Specify: white

16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

retail bakery

Jane

Charles LeRoy Combs 19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Berts Drive, Lothian, MD 20711

Frances

Lloyd E. Deans III, son 20a. Method of Disposition 1 ☐ Burial 2 ី Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 9/4/2010

20c. Location - City or Town, State Alexandria, VA

Oakman

21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury

Immediate Cause (Final

Metastalic Adenocarcinoma of Stomach Due to (or as a consequence of): Due to (or as a consequence of):

Due to (or as a consequence of):

that initiated events resulting in death) Last

23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death

Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown

IF FEMALE:

Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown 24a. Was an autopsy performed

28f. Location (Street and Number or Rural Route Number.

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Approximate Interval Between Onset and Death

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

27. Manner of Death

1 Natural
2 Accident 5 Pending Investigation Accident A 6 Could not be 3 ☐ Suicide 4 ☐ Homicide

determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at work?
1 Yes 2 🗌 No

Other:

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

6 anne

D30641

29d. Date signed (Month, Day, Year)

Back River Necle Road Baltonny Maylow 2122 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

201-109 Kamesh 31. Date filed (Month, Day, Year) 32. Registra/s Signature

Hospital or Attending Physician: The law requires this certificate Division of Vital funeral director, 24 hours after deat Funeral Director: filled in by completed To the within 2

State

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Sept. George Christopher Dodds 2:30 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Allegany** Egle Nursing Home Lonaconing 8. Date of Birth Oct. 6,1919 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Hours 1 🌠 M 2 🗆 F Laureldale, WV Director 90 Yrs. 232-60-5326 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Mineral New Creek 10e. Street and Number 10g. Citizen of What Country? Funeral HC 72, Box 162 26743 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces' Completed by 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 - Widowed 4 - Divorced White Year or Dates. WW II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Self employed farmer agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Christopher W. Dodds Annie Agnes McNeill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Dodds/ Nephew HC 72, Box 162 New Creek, WV 26743 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) McNeill Cemetery 2010 Laureldale, WV 21. Signature of Funeral Service Licer 22. Name and Address of Facility Smith Funeral Home S. Main Kevser. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death?
1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 **N**0 1 Tes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Acciden injury 5 Pending 1 ☐ Yes 2 ☐ No. Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours a

City or Town, State) 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

126907

SEPTEMBELIS 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

925 Bishop Walsh Road Cumberland, MD 21502

Harjit Sidhu, M.D.

32. Registra 's Signature

31. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 8 Physician/ 2010 2350 РМ Charles Samuel Dunlap, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 176 Deaver Road E1kton Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** 1 🕅 M 2 🗆 F DEC 11. Year 28 Mary land Director 215-24-0645 81 Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked outher than "natural", or items 5.8 or 28a-f sho amportant: If item 27 is marked outher than "natural", or items 5.8 or 28a-f sho and in intry or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director 1 Yes 2 X No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 176 Deaver Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No Completed by 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Owner/Operator Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Dunlap Ada Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene C. Dunlap/Wife 176 Deaver Road, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Elkton Cemetery on Cemetery 14, 2010 Elkton, MD
22. Name and Address of Facility Hicks Home for Funerals, Signat e of Funeral Service Licenses 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) ed by the a Yes 2 No 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been siç , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 🗷 No certificate or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera 1 Natural 5 Pending work? 1 Tes 2 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month). and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

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32. Registrar's Signature

Date filed (Month, Day, Year)

21 2010

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		Registrar 1. Decedent's Name	e (First Middle	l ast)			Çe	rtificat	e or L	Jeath	2. Date of Dea	Reg. No	<u> </u>	LU	3. Time of	L4 U
Physicia		Brian	Scott	·	sbree						Month		201	Year	9:46	
Medic Examin		4a. Facility Name (if						4b. City,	Town, or	Location of Death		-		of Death	7.40	
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Funeral Director		5. Social Security Nu. 227–76–09	98	6. Sex 1 XM 2		ge (In yrs. Ia 44	1 yrs. last birthday) 4 Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.				8. Date of Birl (Month, Da May 17	th y, Ye <i>ar</i>) 19 (66	9. Birthp Count V11	lace (State o ry) ginia	or Foreign
a-f show	ctor	Usual Residence of 10a. State MD	10b. County Freder	ick			y, Town or Lo	ocation	_					11	0d. Inside C	ity Limits
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 🔏 Never Marri 3 🗆 Widowed	ied 2 🗆 Marri	12. Was Arm 1 C	s Decedent ned Forces? Yes 2 X es, Give	Ever in U.S	Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:				pecify Yes or No- o Rican, etc.) 14. Race - Am Black, Whi Specify: Wh.			k, White, e	etc.	
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lid be Menta arkec	입	Norman E	Norman Elsworth Elsbree, Jr.							Diane V	iola Mei	senh	elte	er		
nd 2 shou salth and n 27 is rr er traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 North Carroll Street Thurmont, MD 21788														
Page 1 ar nent of Ha int: If iter ry or oth		20a. Method of Disp 1 ☐ Burial 2) 4 ☐ Donation	Cremation		al from State		Place of Disponentery, cre	matory or o	other plac	atory 09,	Date /04/10			City or To		
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Examiner	er	Sequentially list co	nditions,	b. ——	oue to (or as											
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Toth withi Comp	_	29b. Signature and		5 hm	m			290	c License	e number		29d Dat	te signe	d /Month /	Day Year)	
		30. Name and addre	ess of person w	rho complete	d cause of	death (Item (のり	23a) (Type,	Prigt)	n 5	F 7	Lunmovi	p	10	2,	702	
Stat Registra		31. Date filed (Monti	SEP 0 8	2010	32. Fegist	rar's Signa	ture,	barks	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 6, 2010 Physician/ Margaret Lucille Evans 10:33A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Prince George's Renaissance Gardens Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 і 🗙 F Months Hours Min. (Month, Day, Year) ar 21, 1921 Director 504-07-6650 89 Yrs Nebraska 28a-f show 10a State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medic Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No Silver Spring Maryland Prince George's 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3156 Gracefield Road, OP203 20904 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. 1 ☐ Never Married 2 🔀 Married <u>م</u> 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental Fitem 27 is marked of ၉ Joseph LeRoy Trompeter Elizabeth Clara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Dale Evans/husband 3156 Gracefield Rd, OP203 Silver Spring, MD 20904 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important; If it any injury or o ☐ Burial 2 🛭 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 9/9/2010 Woodbine, Maryland 21. Signature of Funeral Service Lip collingation service P.O. Box 784 Rthomas atimar M00957 Beverly 1. Heckrotte, P.A. Clarksville, MD 21029 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Con estive Heart Failure disease or condition Medical resulting in death) Examiner Chronic Lymphocytic Leukemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last burial Physician/Medical that the death certificate be attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 performed Hospital or Attending Physician: Be (director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniury work?
1 Yes 2 No death. Accident Suicide Investigation 24 hours after deal Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the ca within 2 To the i only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

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68760

Box

P.O.

Records,

of Vital

Division

DHMH 17 Rev 7/2000

3110 Gracefield Road Silver Spring, Maryland 20904

30. Name and address of person who completed cause of death Item 23a) (Type, Print)

NP

2010

32. Fegistrar's Signatur

Julaine Harding,

P 09

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Sept. 20 Year 12:43aM Eleanore M. Forney Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil E1kton Union Hospital 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 F Days Months Hours Min. (Month, , *Day*, 88 Yrs 179-18-2660 Director 1922 Apr Usual Residence of Decedent show 10a. State 10b County 10c City Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 28a-f Yes 2 No Pottsville PA Schuy1ki11 10e. Street and Number 10f, Zip Code ō 10g. Citizen of What Country? Funeral with 23a 17901 USA 1340 West Norwegian St. and Mental Hygiene. is marked other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Rusiness Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Theresa Montag George Yeastedt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1855 Old Neck Rd. ELkton, MD 21921 Karen Jackson Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State 9/8/2010 cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) St. John The Baptist Cemetery Pottsville, PA Single re of Funeral Serie 22. Name and Address of Facility
R.T. Foard and Gee
259 E. Main St. ELkton, Name and Address of Facility Gee MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) no Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any cause in the Underlying Cause (Disease or linjury Examine Due to lor as a consequence of that the death certificate be executed use as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No į Month Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. | signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician; The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 2192

DHMH 17 Rev 7/2009

State Registrar

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32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Roy Carl Fielder, Sr. 20 10 4:40 pM August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Severna Park 548 Arundel Drive 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** July 3, Hours 1 🕅 M 2 □ F Year 933 77 **Director** 223-38-5270 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho should be filed within 72 hours after death with the Maryland Director MD Anne Arundel Severna Park 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21146 USA 548 Arundel Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? 1953 Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes If Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 White 1954 1 ☐ Yes 2X No Specify: Specify: 3 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ed other than " Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 9 Federal Government Meat Cutter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ./nOre,
oit. Page 1 and 2 shc.
ont of Health and Ms.
'tem 27 is marked...
vr traumatic ev. Gladese Poole Clarence Fielder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 548 Arundel Drive Severna Park, MD 21146 Ruth Anne Fielder/Wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to Date 2, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept. 2010 1 X Burial 2 Cremation 3 Removal from State MD Veterans Cemetery Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of a peral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. 495 Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ (= M My sema Raws disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 Pregnant 5 Other (specify) Pregnant at time of death Yes signed by the a d be detached for 1 ☐ Yes ∠ L g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autonsy performed? Yes 2 No 1 Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No Hospital: 1 Inpatient 2 ER/Outpatient 3 IDOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 👿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

10411/9

State Registrar

29b. Signature and title of cert

D46052

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar per physician. 9/15/10 Certificate of Death E.T. #1. I. Decedent's Name (First, Middle, Last) 2. Date of Death George Louis Fischer Physician/ George Lewis Fischer September 6 2010 5:20 PM^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Salisbury Wicomico Nursing Home If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD Social Security Number Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 1 🕱 M 2 🗆 F Min. 12/21/1929 80 Director 217-26-1503 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔼 No MDWorcester Berlin ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 344 Ocean Parkway 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ğ 1 Never Married 2 🙀 Married 1 x Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 2 No 1 ☐ Yes 2 ☑ No Specify: Specify: white "natural" Completed 3 🗌 Widowed 4 🗎 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) z should be filed within. th and Mental Hygiene. 7 is marked and other than Elementary/Seconday (0-12) College (1-4 or 5+) engineer Westinghouse Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Estelle Daska George Fischer Page 1 and 2 should ment of Health and M 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernadette Fischer <u> 344 Ocean Parkway, Berlin, MD 21811</u> 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 D Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9/8/2010 Frankford, DE Cape Henlopen Crem 22. Name and Address of Facility The Burbage Funeral Home 21. Signature 108 William St. Berlin, MD 21811 of 1. Unter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of **E**xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Dus to for as a consequence of sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year g Unknown g Unknown has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🌂 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 death? this certificate 1 Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No Certificate: To Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide М 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or inventioning in my prints. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahesha Thimmarayappa M.D.910 Eästernshore Dr Salisbury MD 21804 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death September 1 Physician/ 2010 9:50 Hugh Fowler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel West River 1001 Cosimano Place If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Sex 1 M M 2 □ F Days Hours Min. 05-22-193 Mary Land Director 79 219-76-7893 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 Tes 2 X No West River MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20778 1001 Cosimano Place Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 X Never Married 2 Married 1 Yes If Yes, Give b Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed white Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medicall once." 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) farming farm hand Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Stinnett Daisy James Fowler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cosimano Place, West River, MD 20778 <u> Anne Fowler, sister-in-law</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 9/4/2010 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. 122 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ anex disease or condition resulting in death) Medical Due to (or consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) Pregnant at time of death Yes 2 No ed by the detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signed b should be deta þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 2 👺 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗆 only one 29b. Signature and title of certifier 3854 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 134 Owensmile Bill bavon mo

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney | 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day September 7 2010 1508 Nora Alice Fink 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Cecil E1kton Union Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 🗓 F 30, Delaware 63 1947 213-48-7382 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No E1kton Maryland Ceci1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21921 128 Woolens Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Educational Elementary/Secondary (0-12) College (1-4or 5+) Food Service Institution 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marshall Durkee Annie L. Lovett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert Lee Fink/Husband 128 Woolens Road, Elkton, MD 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Gilpin Manor
Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition September 1 Burial 2 □ Cremation 3 □ Removal from State 10, 2010 Elkton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CIRRHOSIS disease or condition resulting in death) Due to (or as a consequence of): PNEUMONIA Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last SEPSIS Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No

/Medical Examiner attending physician and for use as the burial-tran P.O. cate has been signed by the page 2 should be detached Division of Vital Records, certificate funeral director, this After Hospital or Attending

Physician

/Medical

Examiner

Funeral

Director

28a-f show s 23a or 28a-f shov

item 27 is marked other than "natural", or items other traumatic event, the Medical Examine 1.45

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d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r filed within 7 Hygiene.

permit. Pages 1 and 2 sh Department of Health an Important: If item 27 is r any Injury or other traur

Physician

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

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Completed

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Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 1 Residence 6 \(\text{Other} \) Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P.V. Naye D0065733

18 Registrar

death. thours after death.

uneral Director: A
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24 hours a

To the I within 2.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NARAYANA RAD . V . PULA 126 A RAD NARAYANA 32. Registrar's Signature

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E. HIGH

STREET, ELKINN, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death September 05 2010 Physician/ 3:55 am Arthur Llewellyn Garnes Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Potomac 7710 Fontaine Street 9. Birthplace (State or Foreign Country)
New York If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Days Months 1 🗶 M 2 🗆 F 98 June Director 069-30-1260 Usual Residence of Decedent 10d, Inside City Limits er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a State 10b. Count 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 No Potomac Maryland Montaomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 20854 7710 Fontaine Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. 1 ☐ Yes 2 🗓 No If Yes, Give 9 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify Specify Black Completed 3 X Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare Services Surgeon 5+ t. Page 1 and 2 should be filed with the property of Health and Mental Hygien trant: If item 27 is marked other 1 jury or other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ۵ Emily Dorothy Ann Daniels Arthur Frederick Lawrence Garnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1647 E. Jefferson St., #101, Rockville, MD 20852 Dolores V. Garnes - Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Department or Important: If any injury or 09/09/2010 Silver Spring. MD 4 Donation 5 Other (Specify) Gate of Heaven Cem. Signature of Funeral Service License No#1070 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, b. List only one cause on each line. . Part 1. Enter the disc shock, or heart failur Onset and Death

3 months Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Examiner Ischemic Cardiomyopathy 16 years Sequentially list conditions, Examine Due to (or as a consequence or, ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 No Pregnant at time of death s been signed by the sahould be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?
Yes 2 X No page 2 s death? 1 ☐ Yes 2 ☐ No this certificate **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 X No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ER/Outpatient 3 DOA 1 Inpatient 2 I မူ 28a. Date of injury (Month, Day, Year) 28b. Time of 27, Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: After 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion death. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year)

September 07, 2010

D19294

911, Russell Avenue, Gaithersburg, Maryland 20879

Registrar DHMH 17 Rev 7/2009

State

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32. Ragistrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD.

Melnick.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 31, 2010 Physician/ 11:37 PM Gladys Olive Garner Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Mt. Airy Kline Hospice House If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 92 Months Days Hours July 15, 1918 Maryland 216-30-3590 Director Usual Residence of Decedent or 28a-f show notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director Frederick Maryland Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ь must be r USA 21704 Funeral 7217 Linganore Road items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iten edical Examiner r 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Yes XX No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: **Black** 3 Widowed 4 ☐ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) th and Mental Hygiene. 27 is marked other than ' traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Medical Nursing Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William A. Davis Gladys Jane Norris permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21704 5801 Broad Branch Way, Frederick, Maryland Patrice Harper - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 E Burial 2 Cremation 3 Removal from State 9-4-2010 Frederick, Maryland Fairview Cemetery 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ons and Death Immediate Cause (Final Physician/ CEREDRO - UNSCULAR ACCIDEN HUNH disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Bequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ig physician and as the burial-transit executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Por Month Day Year Pregnant at time of death been signed by the sahould be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hospital or Attending Physician: The law has autopsy page 2 🗌 No certificate 2 1 No I Yes Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) if well Be examiner? 1 ☐ Yes 2 ☑ No Hospital Other: 4 □ Nursing Home 5 □ Residence 6 Nother (Specify) HOS PICE မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4000 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 Yes 2 No after death. 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 - Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 Dille 29c. License number METERNE MEDICAL 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10587 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . うてていく んくいにん ひょんをてつん。 FREDERICK TL 47E FREDERICK 2170 TRAIL 4.0 516 JEDLYE

State Registrar 32. Registrar's Signature

			For State Registrar 1. Decedent's Name (First, Middle, Last)		ryland / Depa <i>Cei</i>	artment of H			eg. No.	2 9 7 4 9	
	Physici /Medio Examin	al	LYNDA KRAFT G 4a. Facility Name (If not institution, give s 12114 Still Por		Rd.	4b. City, Town, o Wortor		SEPTEM		10 2:19p ^M	
	Funeral Director		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday) 8 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. B	irthplace (State or Foreign Country) aryland	
	ath with the Marylan 23e or 28e-f show	Director	MD Kent 10e. Street and Number		10c. City, Town or Lo	10f. Zip Code		1	0g. Citizen of What 0	10d. Inside City Limits 1 ☐ Yes 2 ☐ Xo Country?	
21215-0036	n 72 hours after death with the Maryland "natural", or items 23e or 28e-f show colcal Experiment ast be notified at	by Funeral Di	12114 Still Por	12. Was Decedent Ev Armed Forces? 1 Yes *No If Yes, Give Year or Dates:	ver in U.S. 13.			Specify Yes or No- rto Rican, etc.)	U.S.A. 14. Race - Am Black, Wh Specify: W		
	d within 72 giene. r than "na	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give	dent's Usual Occup kind of work done DO NOT use retired ical Sec	during most of we specify cretary		16b. Kind of Business/Industry Health Care First, Middle, Maiden Surname)		
Maryland	be d la b	To Be	17. Father's Name (First, Middle, Last) Thomas Caltride 19a. Informant's Name/Relationship (Ty		19b. Mailii	ng Address (Street	Thelm	a Kraft	маюн Sumame) r, City or Town, State	, Zip Code)	
Baltimore, Ma	permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 is marke any injury or other traumatic 2006.	1100	Kelli Chambers 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Fune al Service Creases 23a. Pagal. Enter the disease, or compleshock, or hear failure. List only of	lemoval from State	20b. Place of Disponsion Commetery, creating Kent Cr	osition (Name of matory or other place cemation) 2. Name and Address controls and Address center ce	ss of Facility	9/10	Smyrna,	DE.	
68760,	Physician / Medicate be executed particular to a strending physician and a strending physician and duranter as the british fransit	Ical Examiner	Immediate Caufe (Final disease or confliction resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a	consequence of): consequence of):	ilure.					
.O. Box 68		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome o 1 □Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	/		23d. Date of o Month	delivery Day Year	
S, D	en sign	by	Part II. Other significant conditions col	ntributing to death but	t not resulting in the u	inderlying cause gr	ren in Part I.	23e. Did to		co use contribute to the cause of death? 2 No 3 Probably 4 Unknown	
al Record		Completed	25. Was case referred to medical				00 Plan 4 P		sy prior t med? death 2X No 1 □ Y	autopsy findings available to completion of cause of ? es 2 \(\subseteq \text{No} \)	
ion of Vital	ng Physic fter this ce neral direc	atlon: To Be	examiner? 1	1 Inpatien 28a. Date of Injury (Month, Day		of 28c. Inju Wo	er: 4 🗌 Nursing		lence 6 □Other (S low injury occurred	pecify)	
Division	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	al Certification;	3 Suicide 6 Could not be determined	28e. Place of Injuing building, etc.			me, date and pla	City or Tow			
)	To the Hospital of within 24 hours at To the Funeral D completely filled is	Medical	(Check only 2 Medical Examione) 29b. Signature and title of certifier	ner: On the basis of and manner stat	examination and/or in ed.	29c. Licens	opinion, death oc	curred at the time, o		due to the cause(s)	
	Sta Regist	- 4	Patrick 31. Date filed (Month, Day, Year) SEP 0 9 2010	Callahan 32. Registra			wn St.	Chester	rtown, MD	21620	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Agnes S. Green AUGULT Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMURE GOACHINGTON MEDICAL CENTBR ANNE GLEN 7. Age (In yrs. last birthday) If Unde 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day Year) eb. 21,1917 1 □ M 2 🗓 F 215-05-4731 Months 93 Min. Mary land Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Severna Park Anne Arundel MD 1 🗌 Yes 2 🛛 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21146 USA 114 Cedar Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married HEEN HYCMES Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 🔀 No If Yes, Give White 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Korvettes Elementary/Seconday (0-12) College (1-4 or 5+) Lane Bryant Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary McDermott John Scally 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
114 Cedar Road Severna Park, MD 21146 Richard A. Green/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GlenterHaven Memorial Sept. 03, 2010 Glen Burnie, MD 21. Signature of Funeral Service Licensee Rarranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 1 au 495 Ritchie Hwy, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ COLITIS disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Cause (Disease or iinjury that initiated events resulting in death) Last and the bunal by the attending physician stached for use as the bunal Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the ar P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 Pending 1 Yes 2 No Accident Investigation M 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature ٩ 29d. Date signed (Month, Day, Year) sted cause of death (Item 23a) (Type, Print) 10 rive C 01

State Registrar 31. Date filed (Month.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 0132 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fluttering Leaf Trail Unit 206 Anne Arundel Odenton 8. Date of Birth (Month, Day, Year If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 🗆 M 2 🔀 Days Virginia Director 578-26-3773 89 Yrs 1921 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland | Anne Arundel Odenton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 8621 Fluttering Leaf Trail Unit 206 21113 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: White Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Virginia Grimes George Corbin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 8621 Fluttering Leaf Trail, #206 Odenton, MD 21113 Linda Chester/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1

■ Burial 2

□ Cremation 3

□ Removal from State cemetery, crematory or other place, Washington National Cemetery 9-3-2010 Suitland, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, block, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eukemy Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami executed Cause (Disease or imjury that initiated events and -tran Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death the 9 \ Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has e 2 page performed Yes 2 N certificate 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? DAUGHTERS Hospital: 2 X No Other: 1 🗌 Yes မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Wher (Spe this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 2 Accident 3 Suicide (Month, Day, Year) injury 5 Pending work death. М 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I only one) 29b. Signatuje and title of certifie me and address of pe 31. Date filed (Month. Day, Year) State Registrar

Physician /Medical

J.	Examir	ner	4a. Facility Name (If not institution, g. 12201 EAGLES				or Location of Death MANTOWN	4c. County of Death MONTGOMERY					
	Funeral Director	Г		Sex 7. Age (In yrs 1	s. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Day FEB 23	h y, Year) 1942	9. Birth Cou N	nplace (State or Foreign untry) • C •		
	and		10a. State 10b. County	10c. C	ity, Town or Loc	cation					10d. Inside City Limits		
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Marical Examinar must be profilled at	ţō	MD. MONTG	OMERY	GERN	NWOTNAN					1 Xves 2 □ No		
		iec	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Cou	untry?		
	h with	Funeral Director	12201 EAGLES N	EST CT. #E		20	874		USA				
	deat	ıner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. V	Vas Decedent of I	Hispanic Origin? (Spectar), Mexican, Puerto F	cify Yes or No-	14. Rac		rican Indian,		
36	or it	by Fu	1 ☐ Never Married 2 ☐ Married	1 ∐Yes 2 X No If Yes, Give		1 □Yes 2√2 No Specify:					Black, White, etc. Specify: BLACK		
00	hours tural	d b	3 ☐ Widowed 4X Divorced	Year or Dates:		a desile							
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21215-0036	y with giene r thau	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	PROC	CUREMEN	Ť		FED. (GOVE	RNMENT		
	ould be filed Mental Hygi arked other atic event, I	To Be C	17. Father's Name (First, Middle, Las WALTER GARNE	•			Maiden Surnan	1e)					
Maryland	and 2 should I eatth and Men n 27 is marke her traumatic		19a. Informant's Name/Relationship TONYA TWYMAN/D		1	-		-	City or Town, State, Zip Code) ON , MD . 20735				
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra once.		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Hemoval from State CITA	Place of Dispos cemetery, crem	Place of Disposition (Name of Date 20 semetery, crematory or other place)					Town, State		
alt	permit. Departr Importa any inju	М	21. Si nature of Funeral Service Lice	ensee		. Name and Addre	•				010		
<u> </u>	20 E # 9	. 69	1- OC		1	WATSON	F.H. 343	5 14th	n ST.,	1.W.	WASH. DO		
	Physician /Medical	i n	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A HYPERTENSION Due to (or as a consequence of):										
	Examiner	_	Sequentially list conditions,	b. ASTHMA Due to (or as a conse									
Box 68760,	icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Emer underlying Cause (Disease or injury that initiated events resulting in death) Last										
o.	that the death certificate be executed ed by the attending physician and detached for use as the burat-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) 23d. Date of death 3 □ Ectopic pregnancy 23d. Date of death 4 □ Pregnant at time of death 5 □ Other (specify) 23d. Date of death 3 □ Ectopic pregnancy 23d. Date of death 23d. Date of										
۰, ۳.		>	Part II. Other significant conditions	contributing to death but not re	sulting in the un	iderlying cause gi	ven in Part I.	23e. Did to	bacco use cont	ribute to	the cause of death?		
ğ	The law requires ate has been sign page 2 should be	d ba						1 □ Y	′es 2□No	3 X Pro	obably 4 🗆 Unknown		
တ္ထ	e law re has ber e 2 sho	Completed						24a. Was a			topsy findings available		
Ě	The I	mo.						autop perfor 1 ☐ Yes	rmed?	death?	completion of cause of		
/ita	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Death						
£	Physician: r this certific ral director, I	၉	1 Tes 2 No	Hospital: 1 ☐ Inpatient 2 ☐		t 3 ☐ DOA Oti	her: 4 Nursing Hom	e 5 Resid	dence 6 □Oth	ier (Spec	cify)		
Division of Vital Records	ng ffe	ation:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	M 28c. Inju	ıry at rk?]Yes 2 □No	3d. Describe h	now injury occur	ed			
Divi	i ji fi o	Certification:	3 ☐ Suicide 6 ☐ Could not to determined		nome, farm, stre	eet, factory, office	2	Bf. Location (S City or Tow		er or Ru	ral Route Number,		
	the Hospital in 24 hours a the Funeral I	Medical	29a. Certifier (Check only one) Certifying P Medical Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the t	time, date and place, a opinion, death occurre	nd due to the d at the time,	cause(s) and m date and place,	anner as and due	s stated. to the cause(s)		
	To the within 2 To the comple	2	29b. Signature and title of certifie	wany		29c. Licen: D0	se number 0067634	:	29d. Date signe 9/8/		n, Day, Year)		
B	10		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, F	Print)							
Ne	10		SANDRA L. SW. 31. Date filed (Month, Day, Year)	ANN MD 1396 32-Registrar's Sign	PICCAF	RD DRIV	E, ROCKVI	LLE,	MD. 20	850			
	Sta Registr		SEP 0 9 2010	Been S.	park	/							
DH	ULL 17 Day 1/0/	201			/								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day Year Dale Calvin Hida ent 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Olney Montgomery Montgomery General Hospital 5. Social Security Number 8. Date of Birth (Month, Day, Year) Sept. 25, 1948 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Hours 1 ₩M 2 □ F 215-46-2189 Maryland Director Usual Residence of Decedent or 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director 1 Yes 2 No PA Franklin Greencastle 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 23a USA 11085 Williamsport Pike 17225 27 is marked other than "natural", or items 23. traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married à Yes 2 No Yes, Give 1 Yes 2 No Specify: and 2 should be filed within 72 hours afte. Health and Mental Hygiene. Specify: White 3 Widowed 4 K Divorced Completed Year or Dates. Vietnam 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Fleet Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Emily Tobin Jennings Hida 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 London Bridge Court, Silver Spring, MD 20906 f Health a Brigida Hida/Sister-in-Law injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otf Sept. Date George Washington 1 A Burial 2 Cremation 3 Removal from State Adelphi, MD 4 Donation 5 Other (Specify) 2010 Cemetery 21. Signature of Funeral Segrece Licensee ²² Name and Address of Figure Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ 0 2110 Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events Orona attending physician and for use as the bunal-tran Due to (or as a consequence of resulting in death) Last Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death signed by the a d be detached f 1 ☐ Yes ∠ L 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2 No Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28c. Injury at work?
1 \sum Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending Accident Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 the

State Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

SEP U 8 2010

Baltimore, Maryland 21215-0036

68760

Box (

Records.

Division of Vital

l30 Name and address of person who completed sause of death (Item 23a) Type Printle, Silver Spring, MD 20910

32. Registrar's Signature

29c. License number

racked

63136

29d. Date signed (Month. Day, Year)

Sept, 5, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 07:50 AM SEPTEMBER 06 2010 Robert Coye Heath 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TOWSON SAINT JOSEPH CENTER MEDICAL 8. Date of Birth (Month, Day, Year) June 21, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 1 3 M 2 D F Months Days Hours Min. West Virginia 235-50-3769 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No Anne Arundel Maryland Severn 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? United States 89 Gambrills Road 21144 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black White etc. 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Construction 8 Heavy Equipment Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Lillian Heath Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick, Maryland 21704 9203 Baltimore Road Beverly P. Bowers/daugther 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 9/13/2010 Woodbine, Maryland 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M ire of Funeral Service Lice Komgo M00957 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA disease or condition resulting in death) Due to (or as a consequence o CHRONIC EMPYEMA Secure tietly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ADENOCARCINOMA that initiated events resulting in death) Last Due to (or as a consequence of) GASTROESOPHAGEAL VENCTION 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician Medical Examiner Examiner

and

the attending physician

ģ

signed

has

certificate

After this

Director

or Attending Physician:

The law requires that the death certificate be

Division of Vital Records, P.O. Box 68760

permit. Page 1
Department of
Important: If it
any injury or o

Physician/

Medical

10a. State

Examiner

Funeral

Director

or 28a-f shov

Director

Funeral

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Completed

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21. Sign

IF FEMALE:

or items 23a or 28a-f sho miner must be notified at

Examiner

Medical

traumatic event, the

Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho

Baltimore, Maryland 21215-0036

completed filled in by the

Physician/Medical 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>و</u> SEVERE ANEMIA Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an RENAL FAILURE autopsy perforn I ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA
Date of injury 28b. Time of 28c. ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

> 29c. License number D0041410

To the Hospital of within 24 hours at To the Funeral D 12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P. MEHTA M.D.

29b. Signature and title of certifier

7601 OSLER DRIVER

course

Registrar's Signatur

TOWSON MARYLAND

2010

29d. Date signed (Month, Day, Year)

0

Seplember

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician September 4, 2010 2:00 a M Louvenia Mary Hemphill /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert 7515 Saw Mill Road Lusby If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1 □ M 2 🗷 F SC April 9, 1915 Director 95 220-12-9024 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director Calvert Lusby MD with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 7515 Saw Mill Road 20657 death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: If item 27 Is marked other than "natural", or ite 1 ∐Yes 2 Ka`No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify. 2 3⊠ Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Foster Parent** Childcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic evones. Polly Rosborough Samuel Wesley ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) P.O. Box 1374, 7515 Saw Mill Road, Lusby, MD 20657 Ida Smith - daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1≅Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Veterans Cemetery | September 10, 2010 Owings Mills, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility Sewell Funeral Home, P.A. Blady 1451 Dares Beach Rd., Prince Frederick, MD 20678 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final week **Physician** disease or condition resulting in death) /Medical Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner he law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) P.O. Box 68760. hed by the attending physician detached for use as the buria Physician/Medical as IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant was decedent pregnal in the past 12 months? 1 □ Yes 2 No 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 9 I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by should be 2 No 3 Probably 4 Unknown 1 Tyes een) 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy perform@d certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manuer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 ☐ Accident after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 1 29d. Dalte signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2010 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130 HOSPAD PRINCE FREDERICK MD 20678 ANWAR MUNCHI. MD Since 300 31. Date filed (Month, Day, Year) 32. Registrar Signature State -9 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Hicks William James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Western Maryland Regional Med. Cumberland If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex **Funeral** Months Min. (Month, Day, Year) an. 16,1947 Director 219-48-5228 63 Jan. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Director WV Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12 N. Main Street, Apt. 401 26726 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Completed by 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify. 3 ☐ Widowed 4 🎇 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Supervisor Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္

James Carter Hicks

Gladys T. Baker/Daughter

19a. Informant's Name/Relationship (Type, Print)

20a. Method of Disposition

Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

	1 ☐ Burial 2 ☒ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		e Cumberla	nd Crematory	ept. 20 , 2010	Cumberland	d, MD
-	21. Signature of Funeral Service Licensee	Swith		and Address of Facility S. Main Stre	Smith Fun eet Key	eral Home ser, WV 26	5726
	23a. Part 1. Enter the disease, or complishock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	e cause peach line.	onia	node of dying, such as car	rdiac or respiratory arr	est,	Approximate Interval Between Onset and Death Duceles
as Evaluated	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury that initiated events resulting in death) Last	Due to (or as a consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consec					
ly sicial in mican	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregring 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3 🔲 Ector			23d. Date of de Month	blivery Day Year
ed by L	Part II. Other significant conditions con	itributing to death but not re	esulting in the underly	ng cause given in Part I.		obacco use contribute to	o the cause of death? Probably 4, Unknown
Complete			_		24a. Was a autop perfo	prior to death?	utopsy findings available completion of cause of
2	25. Was case referred to medical examiner?	ospital:		26. Place of Death ((Check only one)		
2	1 LJ Yes 2 MNo	1/Inpatient 2	ER/Outpatient 3		ing Home 5 Resid	lence 6 Other (Spe	cify)
Carc	27. Manner of Death 1. Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No		ow injury occurred	
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci		story, office	28f. Location (S City or Tow	treet and Number or Run, State)	ural Route Number,
Medica	(Check 2 Medical Examine	cian: To the best of my knower: On the basis of examination Practioner: To the best of r	on and/or investigation	, in my opinion, death occu	rred at the time, date a	nd place, and due to the	cause(s) and manner states
_	29b. Signature and title of contrier	0		29c. License number		29d. Date signed (Mont	th, Day, Year)
	Mari	low		D00 332	-80	Sept 15	2010

Box 1324

Allegany

USA

20c. Location - City or Town, State

Marie Dodson

Keyser, WV

Date

21502

Cumberland, MD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Black, White, etc.

White

9. Birthplace (State or Foreign

Washington, DC

10d, Inside City Limits

1 🏋 Yes 2 □ No

DHMH 17 Rev 7/2009

State Registrar 625 Kent Avenue

32. Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunil Gupta, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3^{Day} Physician/ SEPT 2010 7:07A M JEAN ANN IRVINE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRÉDERICK FREDERICK CITIZENS NURSING HOME If Under 1 Year If Under 24 Hrs. 8, Date of Birth 5 Social Security Number g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 87 Min. 1 🗆 M 2 🗹 F 04/12/97/19/23 SCOTLAND 130-44-6556 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. Health and Mental Hyglene. The strems 23a or 28a-f show ther Taramatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗹 No URBANA FREDERICK MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21704 4230 TABLER ROAD SCOTLAND 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 🗆 Never Married 2 🗆 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE If Yes, Give 3 ₩idowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC HOUSEWIFE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JANE ANN SANDEMAN WALTER O. TOSH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4230 TABLER ROAD, URBANA, MD 21704DAWSON MOON/SON-IN-LAW permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 09/04/2010 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State STAUFFER CREMATORY FREDERICK, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Sevice Li ensee 22. Name and Address of Facility .0. BOX 86 HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ nonic 055 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner maestive Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autons perform 1 Yes 2 No Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 1 \(\sum \) Yes Hospital: Other: 2 **N**o ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 6 Could not be ☐ Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and tij 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK, MO 300 WEST NINTH ST 31. Date filed (Month, Day, Year)

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year :53 6 Edna Mae Jackson 09 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death COASTAL HOSPICE AT THE LAKE DALISBURY WICOMICO 5. Social Security Number 6. Sex If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)
MD 7. Age (In yrs. last birthday) **Funeral** Months Days (Month, Day, Year) 2-3-1959 1 □ M 2 🎗 F Hours Director 217-74-0232 50 Usual Residence of Decedent 28a-f short 10a. State 10b. County with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 303 Pine Street, USA Apt B 21826 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Ş 1 Never Married 2 Married 1 Yes 2 No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Poultry Industry 11 Laborer Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ <u>Henry Garden</u> Dorothy Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Tasha Anderson/Daughter 303 Pine Street, Apt B, Fruitland, MD 21826 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SpringHill Mem 9-13-2010 Hebron, MD 22. Name and Address of Facility 917 W. Isabella St Bennie Smith Salisbury, MD 21801 Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ BRRAST CARCINDULA MALIGNANT disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for each nonsequirings of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes No
9 Unknown Month Year Pregnant at time of death signed by the a Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 s autopsy performed? 1 Yes Yes 2 completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျ 1 Tyes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSP14Z 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined n 24 hou. the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

SEP () R

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 28^{Day} **Physician** 2010 4:08 P M Aug. Willie Mae Jackson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Heartland Health Care Center Adelphi If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. 10 / 29 / 25 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F Carolina 84 **Director** 251-36-9587 Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Tres 2 No Director Adelphi MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò USA items 23a 20783 1801 Metzerott Road Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural": or insonce, any injury or other traumatic event 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yoo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 🗙 No Specify à Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DC Government Custodian 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Georgia Key Gus Walton, Jr. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Clinton, MD Tommy L. Jackson/Son 8809 Edison Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Harmony Memorial 9/4/2010 Landover, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Latney's Funeral Home, 210011 21. Signature of Funeral Service Licensee cc0278 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDIOPULMONARY Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence on or Attending Physician: The law requires that the death certificate be executed the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 █ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERIENSION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown DROMARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 2 **K** No 2 □ No 1 ☐ Yes 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Certification: To 5 ☐ Residence 6 ☐ Other (Specify) this 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation after death, 1 ☐Yes 2 ☐ No 2 ☐ Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 Homicide within 24 hours a To the Hospital Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated.

P.O. Box 68760.

Records,

Division of Vital

State

Registrar

DHMH 17 Rev 1/2001

29b. Signature a

29d. Date signed (Month, Day, Year) SEPTEMBER 2, 2010

WAY GREENBELT MARILAND 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 2010 3:50 Aügüst A M ROBERT EUGENE KAUFFMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min March I Year 1946 1 🕱 M 2 □ F Maryland Director 215-42-4143 64 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Frederick Walkersville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21793 26 B West Frederick Street United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by XX Yes 2 ☐ No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Divorced Year or Dates. Vietnam 16a. Decedent's Usual Occupation (Give kind of work done during most of working Truck Of User Settled) & Explosives Technicia 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Construction 12 Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Glenn W. Kauffman Lillian Mae Fogle and is m 19a. Informant's Name/Relationship (Type, Print) Shirley Kauffman / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 26 B West Frederick St. Walkersville, MD 21793 permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sept Date 4, cemetery crematory or other place) Restnaven Memorial Gardens 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 D Ther (Specify) 2010 Frederick, Maryland 21. Signature of Fune 22. Name and Address of Facility Resthaven Funeral Services, Skot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. 23a. Part Inter the sase, or conshock, or heart liure. List or pplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Causa Final Onset and Death Physician/ disease or condition resulting in death) Medical a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): -transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 🗌 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes page 2 should . Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy death? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be Hospital 2 No Other: ဂ္ 1 Tyes 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify After this 28a. Date of injury (Month, Day, Year) 27. Manner at Leath 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending I 24 hours after death. injury thin 24 hours after death. the Funeral Director: After mpleted filled in by the fun Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical

Registrar DHMH 17 Rev 7/2009

State

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29a, Certifier

(Check only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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complete

1/20

P.O.

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

DHMH 17 Rev 7/2009

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August

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10-06836 Cheryl Lynne King				pe or Print ate of Mary		Depai	rtment o	of Hea	ilth and			egible		0	29762
Physician Medical Examine	/ /	- For State legistrar 1. Decedent's Nam	e (First, Midd		VI IX	Cert YNNE I	tificate o	of Dea	th		2. Date of D Month Septem	Day	Year		3. Time of Death 1533 hrs
Medical Examine		4a. Facility Name (INNE	KING	4b. City,		ocation of Death		40	c. County of D Dorcheste		
Funeral	ţ	5. Social Security N		6. Sex	7. Age	e (In yrs. la:	st birthday)		der 1 Year	If Under 24Hrs	. 8. Date of		/DD/YYYY) S	. Birth	place (State or
Director		215-72-3	3267	1 M 2 X		51	Yr	Mont s.	ths Days	Hours Min	01	/24/19		oreign Coun	try) VIRGINIA
any	-	Jsual Residence o I0a. State	f Decedent 10b. County			10c. City, 7	Town or Loca	ation	-						0d. Inside City Limits
ne Maryland or 28a-f show any fied at once.	<u>,</u>	MARYLAND	DO	RCHESTER	١ ا				Н	URLOCK					1 Yes 2 No
the Maryland a or 28a-f sh tified at once		I0e. Street and Nu						10f. Z	ip Code			10g. Cit	izen of What	Countr US/	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mendal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Re Completed by Filmeral Director		11. Marital Status			ecedent	Ever in U.S	5. 13. W	as Dece	dent of Hispa	21643 anic Origin? (Sp	pecify Yes or	No-		merica	n Indian, Black,
r death with or items 23 must be no		1 Never Marri		1 Yes		X No	lf.			Mexican, Puerto	Rican, etc.)		White, e		WHITE
urs afte tural", aminer	şĻ	3 Widowed 15. Decedent's Ed		orced If Yes, Give or Dates:		pleted)		nt's Usua		n (Give kind of v		16b.	Specify: Kind of Busin		WHITE dustry
5-0036 ed within 72 hour lygiene. other than "matu the Medical Exa		Elementary/Seco			(1-4 or 5		during r			O NOT use reti	red)				10110
-003 I within giene. ther th		17. Father's Name	(First. Middle.	Last)	4			M		INISTER	(First, Middle	e, Maiden		ELIG	IOUS
215 be filed antal Hy rked of			Ç , <u> , .</u>	DONALD	WHA	LEY							ICKELV	EY	
should and Me	19a. Informant's Name/Relationship (Type, Print) J. EDWARD KING / HUSBAND 19b. Mailing Address (Street and Num									-					
e, M 1 and 2 Health item 2	MARYLAND DORCHESTER HURLO 10e, Street and Number 10f, Zip Code 10f, Zip								Date		Location - Ci				
Pages Pages nent of ant: If or othe	1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: EAST NEW MARKET CEMETERY							ERY 09	/11/2010	Е	AST NE	W M	ARKET, MD		
Balti permit. Departr Import	1	21. Signature of Fu	peral Service	Licensee		-			d Address o		L HOME, P	.A.308 I	HIGH ST., C	CAME	RIDGE, MD 21613
Physician	2	23a. Part I. Enter th			t caused	the death. I	(4)								Approximate Interval Between Onset and
/Medical Examiner		failure. List on mmediate Cause (Final disease	a. Contact S										-1	Death
	ı	or condition resulting		Due to (or a	s a conse	quence of):									
iner		f any, leading to in	nmediate orlying Cause	Due to (or a	s a conse	quence of):	:							V ₂	
ecuted and transit		Disease or injury to events resulting in		Due to (or a	s a conse	quence of):	:								_
be execuician and		UNPENDED		AMENDE	D	_		·							
tox 68760, reath certificate be extending physician for use as the burial-for use as the burial-fosician/Medic:	2:	F FEMALE: 3b. Was decedent past 12 months		ne 1 Liv	e birth	e of pregna	2 F	etal death	-	Ectopic pregna	incy	23	d. Date of de Month	ivery Da	y Year
). Boy the death by the attr whed for a		1 Yes 2 1		9 011	known						les ni				and the state of
signed by libe detach	2	Part II. Other signi	ficant condit	ions contributing	to death	but not res	sulting in the	underlyin	ig cause giv	en in Part I.		_	No 3		e cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans edical Certification: To Be Completed by Physician/Medical E-			-	-								opsy formed?	prio dea	to cor	psy findings available mpletion of cause of 2 No
tal Rician: 7) 2	5. Was case references	red to medica	Hospital:	<					f Death (Check		7			1530
n of Vi ling Physi After this funeral dir	1	1 Yes 7. Manner of Deat 1 Natural		28a. Da	Inpatier ite of Injur nth, Day,Ye	v 	ER/Outpatien 28b. Time of FOUND:		28c. Injury		g Home 5 28d. Describ Subject st	e how inj	ence 6 🗸 (Other: S	Scene
Division o spital or Attending nours after death. neral Director: Aft filled in by the fune Certification:		2 Accident 3 Suicide	6 Coul	stigation Sep 7 d not be	, 2010 ace of Inj	ury - At hor	1528 hrs ne, farm, stre	et, factor		Iding, etc.	or Town	State)			l Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		9a. Certifier 1 Check only	Certifying Pl	hysician: To the b		knowledge				and place, and	due to the ca	use(s) ar		stated	
To the Ho within 24 To the Fu Completely	2	9b. Signature and		and manne		4 - 1 -			c. License r				Date signed		
		h	1 h	N. L	4V			7	O.C.M.	.E.		Sep	otember 8	201	0
	3	0. Name and addr Ling Li, MD		nt Medical Ex	aminer	111 F	Penn Stre	et, Balt	imore, M	D 21201					
State Registra	Ť	1. Date filed (Mont		2 2010 32.	Regionar	's Signature	D. 18	back							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland		artment <i>tificate</i>			and M		giene Reg. No.	10	2976	, 3
	Physici	an	1. Decedent's Name (First, Middle, LE FERN LE			-					2. Date of De Month Sept.	ath Day 6	2010	3. Time of 8:20	Death A M
	/Medio	er	4a. Facility Name (If not institution, gi 9907 Cervine La	ve street and number) ane, Apt. 1	L		R	anda	Location o	own		Ва	unty of Death	ce	
	Funeral Director			Sex 7. Ag 1 □ M 2 🖽 F	ge (In yrs. Ia	st birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bird (Month, Da 06/05/	h y, Ye <i>ar)</i> 1927	9. Birth	place (State of Intry) PA	r Foreign
	Maryland B-f show	tor	10a. State 10b. County MD Baltin	nore	10c. City,	Town or Lo Randa		wn						10d. Inside Ci 1 ☐ Yes	
	or 284	Direc	10e. Street and Number				10f. Zip		0.0				of What Cou	-	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importents: If item 27 is marked other than "neturel", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be neitiked at ances.	y Funeral Director	9907 Cervine Lar 11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	,	i	Was Deced 1 Yes, spec 1 Yes 2			gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	- 14.	ed State Race - Amer Black, White recify: Wi	ican Indian,	
Maryland 21215-0036	within 72 hour ene. than *neturel	Completed by	15. Decedent's E(Specify only highest given the start of	Education	5+)		dent's Usua kind of wor DD NDT us maker	k done d e retired,	ation Juring mos	t of work	ing		of Business/l		
yland 2	ould be filed within Mental Hygiene. arked other than ' atic event, the Ma	To Be Co	17. Father's Name (First, Middle, Las John Taganowski	t)					Ţ	Jnkno					
Mar	12 sho h and 7 is mu trauma		19a. Informant's Name/Relationship Linda Leech - Da)						al Route Number				33
re,	Pages 1 and ment of Healt ent: If item 2 ury or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	☐Removal from State		ace of Dispo metery, cren dent	sition (Nam natory or of	ne of ther place	θ)	-	7/2010	20c. Locat	over, N	own, State	.55
Baltir	permit. Page Department of Importent: If any Injury or QDCE.		21. Signature of Pineral Prvice lice	ensee	0/4//	22	. Name an	d Addres	s of Facili	y Hai	ry H. V	Witzke	's Far	nily F.	
4	Pnysician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List onlimmediate Cause (Final disease or condition resulting in death)	mplications that cause y one cause on each li a. Alzhein Due to (or as	ner's	Demen:		e of dying	g, such as	cardiac	or respiratory a	rrest,		Approximat Interval Bet Onset and 8 year	ween Death
	Examiner	er	Sequentially list conditions,	b. Due to for as	y Art	ery D	iseas	е						20 yea	rs
	be executed ician and burial-transit	Examin	Sequentially list conditions, the leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Hyperli										20 year	rs
<u> </u>	ys e	cai		Chronic	: Obst	ructi	ve Pu	lmon	ary I	Disea	ase (CO	PD)		30 yea	rs
P.O. Box (law requires that the death certifica as been signed by the attending ph .2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3□	Ectopic pro					230	i. Date of deli Month	-	Year
rds, P.	w requires that been signed by should be deta	Ď	Part II. Other significant conditions History of Pulmo					ause give	en in Part I			obacco use		the cause of o	
l Reco	The ate h page	Completed	Lung Cancer					-			24a. Was auto perfo 1 ☐ Yes		24b. Were au prior to death? 1 Yes	topsy findings completion of c	available ause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	251		h (Check only		70 (2		
	Jing After fune	ation; To	1 Yes 2 PNo 27. Manner of Death 1 PNatural 5 Pending 2 Accident investigati	28a. Date of Inju	шгу	ER/Outpatier 28b. Time of Injury		8c. Injury Work	4 🗆 INI		ome 5 Resi 28d. Describe			ory)	
Divis	itel or Attencers after death al Director: led in by the	Certification;	3 Suicide 6 Could not determine	286. Place of III	jury - At hou tc. (Specify,	me, farm, str	eet, factory	, office			28f. Location (City or To	Street and N wn, State)	Number or Ru	ral Route Nun	nber,
	To the Hospitel within 24 hours a To the Funeral (completely filled	Medical	(Check only 2 Medicel Expone)	Physician: To the best aminer: On the basis of and manner st	of examinati		vestigation	in my or				date and pl		to the cause(s	s)
	with Con		29b. Signature and title of certifier	atalun	A	0	H	foc	40			09	1091	1	2
	Sta	ato.	Bonnie Catalans 31. Date filed (Month, Day, Year)	00 5450	death (Item Kno rar's Signat		oth D	r. 5	Stc.	250	Colu	embi	a, M	2016	145
	Regist			2010 Ann	une)		arke	/							

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	F leds	State of Maryla				•	•	ne.
	State Registrar		Ce	rtificate of L	Death		Reg. No	0 29764
Physician/	1. Decedent's Name (First, Middle, I Robert D.	,				2. Date of Dea	ath Day Y	3. Time of Death
Medical	4a. Facility Name (if not institution, g	Larrabee		4h City Town	ulas Paras Davi	Septem	<u>ber 2 20</u>	<u>10 1:45 A ^M</u>
Examiner	Casey House Ho			Rockv:	r Location of Deat	tn	4c. County of	Death gomery
Funeral	Social Security Number 6	. Sex 7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h 9	. Birthplace (State or Foreign
Director	115-24-1809 Usual Residence of Decedent	¹ X M ² □ F	Yrs.	Months Days	Hours Will		9 1931	New York
show d at	10a. State 10b. County		City, Town or Lo	ocation				10d. Inside City Limits
Mary 28a-f otifie	Md. Montg	omery	De	rwood				1 ☐ Yes 2 🔀 No
leath with the Maryland tems 23a or 28a-f sho er must be notified at Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
ems 2	18801 Woodway	12. Was Decedent Ever in U	J.S. 13.	2085 Was Decedent of H		inecify Yes or No-		States American Indian.
fter de contra d	1 Never Married 2 Marrie			Was Decedent of H		to Rican, etc.)		White, etc.
ithin 72 hours af lene. r than "natural" the Medical Exa	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 🕅 No			Specify:	White
an "na Medio	15. Decedent's (Specify only highest	grade completed)	(Give	dent's Usual Occup kind of work done (O NOT use retired)	during most of wo	rking	16b. Kind of Busir	ess Industry
withir giene giene that the the Co	Elementary/Seconday (0-12)	College (1-4 or 5+) 5+		Scientis			Phy	sics
oe filed vantal Hyg wed other c event,	17. Father's Name (First, Middle, Las			-		me (First, Middle,		
d Men d Men marke natic	William Larr				Doro			
Ilth an Ilth an Ilth an Ith an Ith Ith Ith Ith Ith Ilth Ith Ilth Ilth	19a. Informant's Name/Relationship Ramona R. Larra						; City or Town, State , Marylane	
1 and of Hea item	20a. Method of Disposition	206.	Place of Dispo	osition (Name of		Date	20c. Location - Cit	
Page ment c	1 ☐ Burial 2 🕅 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		-	natory or other place itan Cren	1 00 /	06/10	Alexand	ria, Virginia
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	21. Signature of Funeral Service Lice	ensee	22	2. Name and Addre	ss of Eacility. I. Barber	Funeral	Home	
	23a. Part 1. Enter the disease, or co	omplications that caused the de		P. O. E	80x 5038	Laytons	ville, Mo	1. 20882 Approximate
Physician/	shock, or heart failure. List only Immediate Cause (Final	y one cause on each line.		reatic Ca		or respiratory and		Interval Between Onset and Death
Medical Examiner	disease or condition resulting in death)	Due to (or as a conse		realic Ga	meer			
	Sequentially list conditions,	b. ———						
xecuted n and al-transit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a conse	quence of):					
s be executed ysician and e burial-transit	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
hysiciar he burit		d	_					
ertifica ding pl se as t	IF FEMALE:	23c. If yes, outcome of pregr	anov					
atth ce attence for us	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Birth 2 Fe	tal death 3	Ectopic pregnanc Other (specify)	У		23d. Date o Month	f delivery Day Year
nt the death certificate I by the attending phy stached for use as the Physician/Medi	9 Unknown	9 🗌 Unknown						
gnec oe de	Part II. Other significant conditions	contributing to death but not re	esulting in the u	ınderlying cause giv	en in Part I.			te to the cause of death?
equire						1 L Y		Probably 4 🖺 Unknown
The law require sate has been si page 2 should I						24a. Was a autop	sv prior	e autopsy findings available r to completion of cause of th?
in: The tifficate for, page	25. Was case referred to medical	1		26 PI	ace of Death (Che	perfor	2 ☑ No 1 ☐	Yes 2 No
hysicia nis cert direct	examiner? 1 🗌 Yes 2 🔀 No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	Othe			ence 6 🗹 Other (S	pecify) Hospice
ling Pl	27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work	/ at ?		ow injury occurred	
or Attending P after death. Director: After t in by the funers	2 Accident Investigat 3 Suicide 6 Could not	be 280 Place of Injury At h	nome farm stre		Yes 2 No	29f Leasting (Ct	tract and Number a	Dural Davie Alimahan
s after s after la Direction b	4 ☐ Homicide determine	building, etc. (Speci		oct, lactory, omoc		City or Town		Rural Route Number,
he Hospita in 24 hours he Funeral pleted filled	29a. Certifier 1 Certifying Pl	nysician: To the best of my know miner: On the basis of examination	wledge, death o	occured at the time,	, date and place, a	and due to the cau	se(s) and manner as	s stated.
thin 2 the Portion 2 the Porti	only one) 3 Certifying No. 29b. Signature and title of certifier	urse Practioner: To the best of r	ny knowledge, c	death occurred at the	e time, date and pla	ace, and due to the	cause(s) and manne	r as stated.
F 3 F 8	▶7\ O	, Quetcen	P	RIIS	_		9d. Date signed (M	er 2, 2010
	30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, P		0		- pchrempe	2, 2010
35	Diane Ruckert,			caster Mi	.11 Rd.,	Rockv i 11	e, Md. 2	20855
State Registrar	31. Date filed (Month, Day, Year)	7 20 0 Segistrar's Sign	ature A.	Sarke)				

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State of Manyland / Department of Health and Mental Hygiene

			for State of Maryland / L State Registrar		tment of H ificate of D			gieri Reg. N	2111	0 29765
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)				2. Date of De	ath [)av Ve	3. Time of Death
	Medic	al	Agnes Gallagher Long 4a. Facility Name (if not institution, give street and number)		4h City Town or	Location of Death	Septem	<u>ber</u>	13, 20 c. County of D	010 11:20 p.M.
أر	Examin	er	St. Mary's Hospital		Leonardt				St. Mar	_
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	hday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bir (Month, Da	th V Year	9.	Birthplace (State or Foreign Country)
	Director		187-12-6129 1 1 88 Valual Residence of Decedent	Yrs.	,		04/04/1	922	Pe	ennsylvania
	and show dat	ŗo	10a. State 10b. County 10c. City, Town	n or Loca	tion					10d. Inside City Limits
	Mary 28a-f otifie	irec	Maryland St. Mary's Leonard	town		_				1 🗆 Yes 2 🛛 No
	ith the 3aor tben	Funeral Director	10e. Street and Number		10f. Zip Code				Citizen of What	
	ems 2 r mus	inne	25600 Point Lookout Road 11. Marital Status 12. Was Decedent Ever in U.S.	13. Wa	20650 as Decedent of His	spanic Origin? (Spe	cify Yes or No-		ted Sta	ntes merican Indian,
õ	fter de , or it amine	by	1 ☐ Never Married 2 ☒ Married Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	If Y	′es, specify Cubar □ Yes 2 🛣 No	i, Mexican, Puerto	Rican, etc.)		Black, W	/hite, etc.
215-0036	ours a atural'	ompleted	3 Wildowed 4 Divorced Year or Dates.		nt's Usual Occupa			101	Specify:	White
<u>ن</u>	า 72 h :. an "na Medio	mpl	(Specify only highest grade completed)	(Give kir.		uring most of worki	ng	166.	Kind of Busine	ess Industry
7	l withii ygiene her th t, the	ျပ	1 но	omem	aker			Ow	n Home	
yland	oe filec intal H ced ot s even	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	, -			, le
Ž	ould to	1	Thomas Jerome Gallagher 19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing		Madelyn I				
, Mar	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Health and Mental Hygiene. The marked other than "hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at				·	Leonardt			0650	, _,,,
ore	e 1 an tof He Ifiten or oth		20a. Method of Disposition 20b. Place of cemeter. 1 □ Burial 2 Ⅸ Cremation 3 □ Removal from State cemeter.		tion (Name of tory or other place) (e	Date	20c.	Location - City	or Town, State
baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot	1	4 Donation 5 Other (Specify) Brinsf							Hall, MD
pa	permi Depar Impoi any ir once,	Ì	21. Signature of Funeral Service Hoose Edward N. Brinsfield, Jr. M0005							Home, P.A. MD 20650
			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	not enter	the mode of dying	, such as cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
P	h sician/ Medical	d Y	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of the condition of the conditio							Onset and Death
- April 1	Examiner		Server e- muli		weak	ness				
-	n #	nine	ff any, Isaang to in mediate Sue to for as a consequence of cause. Enter Underlying							
	icate be executed physician and s the burial-transi	edical Examiner	Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of the	of):						
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0/0	ng ph) as th		IF FEMALE:							
So xog	ath certificate be executed attending physician and for use as the burial-transit	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fear death		Ectopic pregnancy Other (specify)	/		(9	23d. Date of Month	delivery Day Year
Ď -	ne des y the s ched f	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	5 🗆 (other (specify)					
Γ. 5	s that t gned b oe deta	by	Part II. Other significant conditions contributing to death but not resulting in	in the und	derlying cause give	en in Part I.				e to the cause of death?
Sp	equire een si nould l	eted								Probably 4 Unknown
Vital Records,	ne law r ate has b bage 2 sl	Completed					24a. Was auto perfo	psy orm <u>ed</u> ?	prior deat	e autopsy findings available to completion of cause of h? Yes 2 \(\sum \) No
	cian: ertifica ector, p	Be C	25. Was case referred to medical examiner?			ce of Death (Check				
S	Physical this of ral directions of the control of t	2	1 Ves 2 No 1 Inpatient 2 ER/Ou	tpatient	3 DOA Othe	4 ☐ Nursing Ho	me 5 Resi			pecify)
ב ב	ath. ;: After e fune	icate		njury	work	Yes 2 No	zou. Describe i	10W Hiji	ury occurred	
JIVISION OF	or Atte after de Directo I in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, stree	t, factory, office		28f. Location (City or Tov			Rural Route Number,
נ	In the Hospital or Attending Physician: The law requires that the death certin thin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, conditions only one) 2 ☐ Medical Examiner: On the basis of examination and/or only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge.	or investig	ation, in my opinio	n, death occurred at	the time, date a	and plac	ce, and due to t	the cause(s) and manner stated.
	vith Co 1		29b. Signature and title of certifier Melmi Do A Waleh - MD.		29c. License	number 6473		29d. C	Date signed (M	onth, Day, Year) 2010
lle	·		29b. Signature and title of certifier Melmi D a Lufe L MD. 30. Name and address of person who completed cause of death (Item 23a) (I McN d ad A Khlaghy' St. Mary') 31. Date filed (Month, Day, Year) SEP 16 2010 32. Registrar's Signature	Type, Prin	nt) tal,	Leonard	town,	MI	0 2	0650
	Stat Registra		31. Date filed (Month, Day, Year) SEY 16 2010 32. Registrar's Signature	pa	ule					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 0 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year <u>11:</u>30 Рм Dennis Matthew Langley 2010 September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospital Mary's Leonardtown If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** 1 🔯 M 2 🗆 F Months Days Hours 83 Yrs. Director 213-22-0244 Maryland March 28. Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland must be notified at Director 1 🗌 Yes 2 🗶 No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code "natural", or items 23a or 10g. Citizen of What Country? 20760 Hermanville Road 20653 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 's any injury or other traumatic event, the Magnos. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Richard Langley Eva Corset 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20760 Hermanville Road, Lexington Park, MD 20653 <u>Katherine Langley / Wife</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State September 21. 4 ☐ Donation 5 ☐ Other (Specify) St. Luke's Cemetery Scotland, Maryland 2010 21. Signature of Funeral Service 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 Jardener 23a. Parl 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) , Medical Due to (or as a consequence of Examiner Sequentially list conditions Examiner It any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of g physician and is the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death 1 Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ZHEIMER'S 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗙 No Other: မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation
Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar VENKATA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NARASIMHAM

31. Date filed (Month, Day, Year)

25500 Point Lookout Road, Leonardtown, MD 20650

Fabian Martin Lopez
10-06321 Plea
UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 20757

JNK UNK		1- For State	tate of Maryland	•		of Dea		entai H		Pag No	201	J 25	101
Physicia		Registrar 1. Decedent's Name (First, Mide	dle,Last)						2. Date of De Month	Reg. No. ath Day	Year	3. Time of	
Medical Exami	ner	Fabia	an Martin Lop			I dh. Cit.	Town, or Locat	(D th	August 2	1, 201	0 c. County of De	1548	hrs
		St. Mary's Hospital	on, give street and number)			nardtown	ion or Death			St. Mary's	ain	
Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. las	t birthday)			Jnder 24Hrs		irth(MM	/DD/YYYY) g.	Birthplace (Sta	ate or
Director		None	1 X M 2 F	19		Yrs. Mont	hs Days H	ours Min.	01-10)-19	91	reigrGuate Country)	emala
à à		Usual Residence of Decedent 10a. State 10b. County	/	10c. City, T	own or Lo	cation						10d. Insid	e City Limits
daryland 28a-f show any 1 at once.	١	MD Fred	erick	F	'rede	rick						1 X Ye	s 2 No
daryla 28a-f	Director	10e. Street and Number					p Code			10g. Cit	izen of What C	ountry?	
h the N	ᄒ	1415 Key Park					702				temala		
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 N	12. Was Decedent Married Armed Forces	?			ent of Hispanic ify Cuban, Mexi			0-	14. Race - An White, etc	nerican Indian, :	Black,
fter de		3 Widowed 4 Di	1 Yes 2 ivorced If Yes, Give Year or Dates:	X No	1[X Yes 2	2 No spe	oifyGuat	emalan		Specify:His	spanic	
natura	ed by	15. Decedent's Education (Sp	ecify only highest grade cor		16a. Deced	dent's Usual	Occupation (G	ive kind of w	vork done	16b.	Kind of Busine	ss/Industry	
36 in 72 l	plet	Elementary/Secondary (0-12) College (1-4 or	5+)		Labore			,		Const	ruction	ì
21215-0036 Juld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner.	Completed	17. Father's Name (First, Middle	e, Last)					ther's Name	(First, Middle,	Maiden	Surname)		
21215-Culd be filed a Mental Hygi marked oth	B	Nalberto Marti							op e z Mo	_			
Baltimore, MD 21215-0036 bemit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 77 is marked other than nigury or other traumatic event, the Medica	٩	19a. Informant's Name/Relation	(Cous	sin)		-	s (Street and I Parkway			-	•		
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	ŀ	Teodoro Martin 20a. Method of Disposition			ace of Disp	osition (Na	me of cemetery		Date		Location - City		
TOF Pages ent of nt: If		1 X Burial 2 Cremation 4 Donation 5 Other S		416		other place emeter		09-	14-10	Gu	atemal	а	
taltii	Ì	21. Signature of Funeral Service	e Licensee				Address of Fa	cility W.F.	I. Baco				[nc.
	4	23a. Part I. Enter the disease, o					4th St						nate Interval
Physician /Medical		failure. List only one cause	on each line.	tile death. D	o not onte	i the mode	or dying, saare	as cal diac of	respiratory ai	rest, sin	Jok, of fical	Between	Onset and Death
Examiner	ı	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	equence of):		<u> </u>							
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b Due to (or as a cons	edilence of).									
	Examiner	cause. Enter Underlying Cause	с										
ted d ansit	Ä	events resulting in death) Last	Due to (or as a conse	equence of):									
: 68760, certificate be executed noting physician and use as the burial - transit	Medical	UNPENDED	AMENDED										
760, icate be physical the burn	/We	IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes, outcor	ne of pregna			- 🗆			230	d. Date of deliv	J. J	
lox 6876 leath certificate a attending phy for use as the b	cian	past 12 months?	4 Pregnant at	time of death	_ =	Fetal death Other (Spe		opic pregna	ncy		Month	Day	Year
Box ne death or the atten	Physician//		9 Unknown						[02 200				
P.C	ক্র	Part II. Other significant condi	tions contributing to death	n but not rest	ulting in th	e underlying	g cause given ir	Part I.		_	use contribute No 3 P		
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of Vital ig Physician: ther this certifineral director,	인	examiner? 1 ✓ Yes 2 No		ent 2 🗸 El			OOA Other		Home 5		nce 6 Ot	her:	
	盲	27. Manner of Death 1 Natural 5 Pen	28a. Date of Inju (Month, Day,Y FOUND:	'ear\ I	8b. Time o FOUND:	of Injury	28c. Injury at W 1 Yes 2	id	28d. Describe Subject dro		ary occurred		
Division tal or Attendi rs after death al Director: A	licat	2 🗸 Accident Inve	estigation Aug 21, 2010 28e. Place of In		442 hrs e, farm, st	reet, factory			28f. Location (Street a	nd Number or	Rural Route N	umber, City
Division At ours after derail Direct filled in by	Certification:		ermined (Specify) Riv	er				F	or Town, S Point Lookou	State) t State	Park, Scotla	nd, MD	
0 - = >			hysician: To the best of maniner: On the basis of exam										
Your Vithi Comp	Medical	29b. Signature and title of certifi	and manner stated.	alon and	. J. 1176311		c. License numb		ano amo, uate		Date signed (I		ar)
		- 1/	/ (-				O.C.M.E.			1	ust 22, 201	_	
00145	ŀ	30. Name and address of person											
OCME		Mary G. Ripple MD.	Deputy Chief Medic		ner 1	11 Penn	Street, Balt	imore, M	D 21201				
Sta Registr		31. Date filed (Month, Day, Year)	3Z. Registral	r's Signature	ares	•							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 6, 2010 **Physician** John Joseph McBurney, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Prince George's Laurel Regional Hospita aure If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Hours Voor Days 1 □XM 2 □ F Director 201-14-6758 84 Aug. 1, 1926 Ireland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examination and Injury or other traumatic event, I'm Medical Examination and Injury or other traumatic event, I'm Medical Examination and Injury or other traumatic event, I'm Medical Examination. 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland P.G. 1 ☐ Yes 2 ☐ XNo Director Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9428 Nicklaus Lane 20708 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Almed Toless: 1 1 2 Yes 2 No If Yes, Give Year or Dates: 1944-46 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Attorney Law 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dennis Joseph McBurney Mary Esther Grant 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John J. McBurney, Jr./Son 9428 Nicklaus Lane, Laurel, MD 20708 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Sept. 2010 11 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins
500 University Blvd. 21. Signature of Funeral Service Licensee Funeral How W., Silver Home Inc. ver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on you example cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardia 30 min. disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of spital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funered director, page 2 should be deteched for use as the burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) P.O. 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1∐Yes 2∭XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

within 24 hours a

To the Funeral L

State Registrar

29a. Certifie (Check only

29b. Signature and titletof certifier

Peter R. Hammond, MD

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D23685

7900 Van Dusen Rd.

29d. Date signed (Month, Day, Year)

September 6, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month ep 11, 2010 7:10A.M Malcolm Sr. Paul David Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 16108 Cresapmill Road Allegany Oldtown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) M/ID 8 Date of Birth **Funeral** Hours Min Months Month Day Yes 233-58-3082 1938 MD Director Usual Residence of Deceden 10a. State Ħ 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director r 28a-f sl notified Allegany 1 Yes 2 XNo MD Oldtown 10e, Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 16108 Cresapmill Road 21555 USA 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If flem 27 is marked other than any injury or other traumatic. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Deputy Sheriff Allegany County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Howard Malcolm Martha (House) Malcolm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife <u>Jacqueline Malcolm</u> 16108 Cresapmill Road Oldtown MD 21555 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 9/14/2010 Oliver Grove Cemetery Oldtown MD21. Signature of Funeral Service Licensee 22. Names carpetiis Purieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician. n W disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death
Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 Probably 4 Unknown 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No Yes 2 🗔 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: ျ 4 Nursing Home I Director: After this die in by the funeral die 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after To the Funeral Direct City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Prantioner: T: the best of my knowle 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause e of death (Item 23a) (Type, Print) Gary Wagoner M.D. 925 Bishop Walsh Drive Cumberland MD 21502 State egistrar's Signature SEP 2 2 2010 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 5, Physician/ 2010 Noel Μ. MacDonald 8:50 p M **Medical** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring 4c. County of Death Examiner Apex Health of Silver Spring Montgomery '. Age (In yrs. last birthday) **70** Yrs. Social Security Numbe If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 213-42-7842 1 **X** M 2 \square F Months Days Hours Min. Dec. 23, Year 1939 Country) D.C. Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director Silver Spring Maryland Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a o with 1 Funeral 20906 USA 2709 Woodedge Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Automobile Industry Parts Locator 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Minnie Pollitte Bert MacDonald ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2709 Woodedge Road, Silver Spring, MD 20906 19a. Informant's Name/Relationship (Type, Print) Anne Foglesong/Niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Sept. 2010 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Metropolitan Crematory Alexandria, VA Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spr Silver Spring, MD 20901 aguago 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between Onset and Death Immediate Cause (Final Physician/ Gangrene disease or condition resulting in death) Medical Due to (or as a consequence of): . Examiner Peripheral Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Fur hours after death.

Furnaral Director: After this certificate has been signed by the attending physician and ested filled in by the funneral director, page 2 should be detached for use as the burial-transit Exam that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Deep Venous Thrombosis, Hypertension 2 No 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🖺 No Other: Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 🖪 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred injury 1 XXNatural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Ho.,
in 24 hours
to the Funeral Dicompleted fille Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) Sept. 7, 2010 D58962

Registrar DHMH 17 Rev 7/2009 Shashank

31. Date filed (Month, Day, Year)

SEP U & ZUTU

and address of person who completed cause of death (Item 23a) (Type, Print)
hashank Patel, MD 18121 Georgia Ave., #102, Olney, MD 20832

parke

Registrar's Signatur

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30 M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Northwest Hospice Randallstown Baltimore If Under 1 Year 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs Birthplace (State or Foreign Country) Funeral Sex 1 M 2 □ F Months Days Hours Min (Month, Day, Year) 12/24/1938 Yrs. Director 220-36-2632 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🔀 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1915 Calais Court 21244 United States "natural", or items Was Decedent Ever in U.S. Armed Forces?
1 ⚠ Yes 2 □ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Banking Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be find Health and Mental item 27 is marked ျ Albert R. Mallonee Claire McCullough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Mallonee Miskelly-Sister 3708 Spring Meadow Drive Ellicott City, MD 21042 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 4 Donation Ardent Cremation 9/7/2010 5 Cher (Specify) Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc ure of Funeral Se vice Licensee M01411 4112 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ v05 disease or condition Medical resulting in death) as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? δ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🗚 Unknown cate has been signated to page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No certificate Yes 2 XN 1 Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital: Other: ပ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier death (Item 23a) (Type, Print

State

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Richard Allen Miller 2010 6:00 PM September Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F Min. Months 216-38-1192 71 Hours Dec. 18, 1938 Mary Tand **Director** Yrs. Usual Residence of Decedent 28a-f shov death with the Maryland 10a, State 10b. County 10c. City, Town or Location notified at 10d, Inside City Limits Director Maryland | Frederick Thurmont 1X Yes 2 No P 10e. Street and Number 10f. Zip Code Examiner must be 10g. Citizen of What Country? items 23a Funeral 21788 ll Elm Street USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ö Black, White, etc. þ 1 Never Married 2 K Married Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced White Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Richard 0. Miller Miller Rheada Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoEllen Miller/ Wife 11 Elm Street, Thurmont, MD 21788 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Blue Ridge Cemetery 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/8/2010 Thurmont, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home, PA 104 E. Main Street, Thurmont, MD 21788 23a. Fartt. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. proprietations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ neumon: disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? perform ours after death.

eral Director, After this certificate I filled in by the funeral director, page 2 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Appatient 2 -ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 \square Pending injury 1 Tes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 \square Homicide within 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year, MO51610

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

		Plea	se Type or						-		_	gible.		
	ı	For State Registrar		of Marylan		artment of I tificate of I		and N	/lental Hy	giene Reg. No	60	0	297	73
Physicia Medic		1. Decedent's Name (First, Middle Luis Nieves	, Last)						2. Date of De Septem		ъ, 2	2016	3. Time of De 10:30	
Examin		4a. Facility Name (if not institution, 12207 Atherton	give street and num n Drive	nber)		4b. City, Town, o						of Death	у	
Funeral Director		5. Social Security Number 578–40–4737	6. Sex 1 🙀 M 2 □ F	7. Age (In yrs. Ia 81	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Jan 1		929		place (State or F	oreign
a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. County MD Monto	gomery	10c. City	,Town or Loc Lver Sp	cation pring						1	1 ☐ Yes 2	
23a or 28 st be not		10e. Street and Number 12207 Athertor	n Drive			10f. Zip Code 20902	2				tizen of \	What Cour		A
Department of health and Mental Hyglene. Indepartment of health and Mental Hyglene. Indepartment if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	2 🔀 No e	11	Vas Decedent of H f Yes, specify Cuba ▼ Yes 2 □ No	an, Mexican	, Puerto	Rican, etc.)		Blac	e - Americ ck, White, White	etc.	
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⊆ .00	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last	c	or as a conseque										
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or, After th	Certificate:	27. Manner of Death 1 KMatural 5 Pending 2 Accident Investig 3 Suicide 6 Could r	ation	of injury h, Day, Year)	28b. Time of injury	28c. Injury work M 1 \square	y at	2	28d. Describe I					
ral Direct		4 ☐ Homicide determi	ned 28e. Place buildir	ng, etc. (Specify)		et, factory, office			City or Tov	vn, State)			Route Number,	
the Fune	Medical	(Check 2 Medical Exonly one) 3 Certifying	Physician: To the be caminer: On the basi Nurse Practioner: 1	is of examination	and/or investi	gation, in my opinic eath occurred at the	on, death oc e time, date	curred at	the time, date a	and place,	, and due	e to the cau	use(s) and manne	er stated.
1 000		29b. Signature and title of certifier	u 7	-		29c. License					-	er 7,	2010	
		30. Name and address of person w Geoffrey Colem	an, MD 13	55 Picca	ard Dr		Rock	vill	e, MD 2	0850)			
Stat Registra	e r	31. Date filed (Month, Ser Year)	8 2010 32. Re	strar's Signatu	ire	6								

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bong Won Nam 9 2010 6:50 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Samaritan House Oxon Hill Prince Georges Social Security Number 8. Date of Birth (Month, Day, Year) 7/23/1924 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Korea **Funeral** 7. Age (In vrs. last birthday) 1 □ M 2 🕇 F Hours Korea Director 213-94-3579 86 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges Oxon Hill 1 🗆 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 304 Careybrook Lane 20745 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 24 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 🗆 Yes 2 🗖 No Specify: "natural", 3 Midowed 4 □ Divorced Year or Dates Korean injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Shoe Factory 6 Factory Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Unknown Unknown t. Page 1 and 2 should b tment of Health and Mer rant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sung Woo Nam-Son 2887 Country Lane Ellicott City, MD 21042 Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s Department of I-Important: If ite any injury or ot cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem.Pk 9/8/2010 Timonium, MD of Femeral Se vice Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. M01411 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cell Lymphoma of Uterus Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2, No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 sate has been signed by page 2 should be detach Completed by autopsy performed **Director:** After this certificated in by the funeral director, pag ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tes Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours To the Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 018082

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) **SEP 0 8**

29d. Date signed (Month, Day, Year) 20746

death?

State Registrar Suitland, MD

5107 Silver Hill Rd.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Heinrich J. Novak 2010 3:04 p^M August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 816 David Drive Arnold Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Ye Months Year) 1 🐼 M 2 🗆 F 214-37-3653 Director 67 1943 Austria Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Anne Arundel Arnold 1 Yes 2 X No 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 816 David Drive 21012 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner: once. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Improvement Carpenter 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Theresa Wachtler Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnold, MD 21012 Gertrude Novak/Wife 816 David Drive 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Sept. 2010 1 Durial 2 X Cremation 3 D Removal from State Metro Crematory 4 Donation 5 Other (Specify) Baltimore, MD 22. Name and Address of Facility Signature of Feneral Service Lie Barranco & Sons, 495 Ritchie Hwy: Severna Park Funeral Home Severna Park, MD 21146 P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ OMPLICATIONS OF CIRRHOSIS OF THE LIVER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day detached the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be det þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No certificate 2 🗆 No completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director: After this Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) PHYSICIAN 09.01.10 meus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Mon Sapy 1) 2 2010

Box 68760

P.O.

Records,

Division of Vital

egistrar's Signature

WIDS KOMEUS, M.D. 2001 MEDICAL PKWY ANNAPOLIS, M.D 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day}20<u>10</u> Month Walter Peter Ne1son September 7:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Asbury-Solomons Health Care Center Calvert Solomons If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Country) New York . Social Security Number 8. Date of Birth (Month, Day, 10/22/19 Funeral 7. Age (In vrs. last birthday) 1 № M 2 🗆 F Days Hours Min. 87 Director 145-18-3254 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a, State within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🖾 No Maryland Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11450 Asbury Circle, Apt. 220 20688 United States 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 H No Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) filed within tal Hygiene, d other than the Publishing Company 5+ Director of Marketing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental For them 27 is marked or rother traumatic even 2 Peter Almberg Nelson Alma Marie Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion Wigstrom Nelson / Wife 11450 Asbury Circle, Apt. 220, Solomons, MD 20688 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If ite any injury or ot once. 1 Burial 2 St Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 09/09/2010 Alexandria, Virginia 21. Signature of Funeral Service Licensee Rausch Funeral Home, P.A. 22. Name and Address of Facility 20 American Lane, P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the debt. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Strake ere brovas auton Physician/ accident disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a nonsequence or) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Property After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) Month Year Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 2 Accident 3 Suicident 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Tes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral L Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The delical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number lactes Dennett N.D D25156 September 8, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar Charles W.

31. Date filed (Month, Day, Year)

Trueman Road, Lusby, Maryland 20657

11845 H.G.

MD

32. Registra

Bennett,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 2018 10:45am Lorena May Kathryn O'Connor Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F Months Hours Min. Washington. 577-42-7647 **Director** 80 lugust Usual Residence of Decedent 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f s notified 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 20906 U.S.A 12114 Selfridge Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11, Marital Status "natural", or ite Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry h and Mental Hygiene. 7 is marked other than "I traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Administrator Law Firm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Gordon A. Joseph O'Connor Lorena May Zimmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12613 Denley Road, Silver Spring, Maryland 20906 William Clark - Cousin 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory 09/10/2010 | Brentwood, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring, MD 20904 N 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Acute Renal Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Obstructive Uropathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ohysician and the burial-transit Cause (Disease or linjury Ovarian Cancer that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Year 4 Pregnant 9 Unknown 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 Yes 2 No 1 ☐ Yes 2 ☐ No this certificate director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No funeral Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: After injury 1 🗷 Natural 5 Pending Accident
Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D68096 September 01, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 1500 Forest Glen Road, Silver Spring. Maryland 20910 Satyam Ashvinkumar Shah, MD.

DHMH 17 Rev 7/2009

State

Registrar

egistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 4 Sonia Lesley O'Neal 2010 7:15 P.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Frederick Airy 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months Days Hours New York 0471171919 Director 050-16-6522 Yrs 91 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location If than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Md. Frederick Frederick 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2532 Emerson Drive 21.702 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: white 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sophia Janis Joseph J. Lesley, Sr. permit. Page 1 and 2 should be Department of Health and Men Important; If Item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn H. Peddle / daughter 2532 Emerson Drive, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 09/07/2010 Smithsburg. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home MO1222 <u>106 E. Church St., Frederick, MD 21701</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): and I-transit that the death certificate be executed Due to (or as a consequence of): g physician a Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 9 Unknown 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 Yes 2 **X**No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law I within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s autopsy performed death? 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 X No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 5 Pending 1 Yes 2 No ☐ Accident Investigation Could not be ☐ Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) (Type, Print) treder 31. Date filed (Month 2. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

			For State Registrar	State of	Marylan	-	artment c tificate c			lental Hy	giene Reg. Nd	7	29779
	Physicia	n/	Decedent's Name (First, Middle	le, Last)	_					2. Date of De	oth		3. Time of Death
	Medic Examir	al	Eugenia S 4a. Facility Name (if not institution	Paslaws			4b. City, Tow	n or Locatio	n of Death	Septem		3, 2010 County of Deat	11:15 AM
marger 1	Examin	er	Bradford Oaks	_				inton	II OI Deatii		- 1	-	George's
	Funeral Director		5. Social Security Number		Age (In yrs. I	ast birthday) Yrs.	If Under 1 You Months Da	ear If Und lys Hours	er 24 Hrs. Min.	8. Date of Bir (Month, Da Mar 7,	th ay, Year)	9. Bir Co	thplace (State or Foreign untry) Hampshire
			003-09-2328 Usual Residence of Decedent	<u> </u>						Mar /,	131) livew	
	rryland a-f sho ied at	ctor	10a. State 10b. County		10c. Cit	y, Town or Loc							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the Ma or 28¢	Dire	Maryland Prince 10e. Street and Number	ce George's		Oxe	on Hill 10f. Zip Coo			T	10g. Cit	tizen of What Co	
	s 23a	Funeral Director	509 Barrymore	Drive				20745			Un	ited St	ates
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorces	If Voc Cive	es? C y No	ħ	Vas Decedent Yes, specify C	uban, Mexic	an, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify:	
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Baltimore,	Page tment tant: It jury or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (ale	1 Jour	ney Cre	mator					Maryland
Balt	permit Depart Impor any in		21. Signature of Funeral Service	Licensee	M00	957 B	Name and According HC everly	idress of Fac The Cre L. He	ewatie ckrot	on Serv te, P.A	ice Cl	P.O. Bo arksvil	x 784 le, MD 2102
			23a. Part Enter the disease, o shock, or heart failure. List Immediate Cause (Final	or complications that cau	ised the deat line.								Approximate Interval Between
	Physician/ Medical		disease or condition resulting in death)		Cereb as a consequ		ular Ac	ciden	t				2 Weeks
	Examiner	ı.	Sequentially list conditions,			,	Cardio	ascul	ar Di	sease			years
	ed sit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or	as a consequ	uence of):							
	cate be executed physician and the burial-transit	Exa	that initiated events resulting in death) Last	cDue to (or	as a consequ	uence of):							
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687	eath certifice attending p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna	ancy						23d. Date of de	diverv
Box 68760	death c e atter ed for u	Completed by Physician/M	in the past 12 months? 1 ☐ Yes 2 🔀 No	1 ☐ Live Bir	th 2 🗌 Feta nt at time of c	al death 3	Ectopic pregi Other (specif					Month	Day Year
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ion	tendin leath. or: Aft the fur	Certificate:	1 X Natural 5 ☐ Pendi 2 ☐ Accident Invest 3 ☐ Suicide 6 ☐ Could	tigation			M	work? 1 Yes 2	□ No				
Division	al or Attendi s after death. I Director: A d in by the fu	Cert	4 ☐ Homicide deterr	mined 28e. Place of	Injury - At ho , etc. <i>(Specify</i>		eet, factory, off	ice		28f. Location (City or To			ıral Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 124 hours after death. To the Funeral Director, feet this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 X Certifyin (Check 2 Medical	g Physician: To the bes Examiner: On the basis	t of my know of examination	ledge, death on and/or invest	occured at the	time, date ar	nd place, ar occurred a	nd due to the ca	ause(s) an	nd manner as st	ated. cause(s) and manner state
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	2		30. Name and address of person	•			rint)			1			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Sep. Physician/ 3,2010 Barbara J. Porter 4:55 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester <u> Atlantic General Hospital</u> 8. Date of Birth
(Month, Day, Year)
March 5, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 1 2 M 2 □ F **Funeral** Days Hours Min. 72 217-34-5709 Yrs. 1938 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 10505 Cash Road 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces 1 Never Married 2 X Married ☐ Yes 2 X No 21215-0036 Specify: White 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tech Clerk Verizon Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en gines. William Gownley Catherine Flynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Robert E. Porter - Husband</u> <u> 10505 Cash Road Berlin, MD 21811</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Cape Henlopen Crem. Sep. 6, 10 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 Williams Street Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause at each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death). Examiner resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year 9 🗌 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the fureral director, page 1 🗌 Yes 2 🗆 No ☐ Yes 2 ☑ 25. Was case referred to medical Medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) State

Registrar

TOD: 16:55

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} September Helen 2010 Oki Roth 6:25 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kensington Nursing & Rehab Kensington Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, 1 □ M 2 🗓 F Months Davs Hours Min. Director 577-54-4228 88 Japan Usual Residence of Decedent 10c. City, Town or Location 10b. County with the Maryland 10d. Inside City Limits Director 28a-f 1 X Yes 2 No Maryland Montgomery Rockville 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 534 Anderson Avenue 20850 United States and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 9 1 Never Married 2 Married Black, White, etc. Completed by 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Asian "natural" 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) the <u>Waitress</u> Restaurant 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental I ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine D. Hessler/friend Laytonsville, Maryland 20882 20917 Sunnyacres Road t: If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 a Date Department of Important: If any injury or 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 9/10/2010| 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 uanita M00957 momas 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ End Stage Renal Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): siclan and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physiclan for use as the buria Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💹 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 XNo မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🔀 Natural injury work? 2 🗌 No Investigation 6 Could not be Accident filled in by the 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

P.O. I of Vital Records, hours after death. Ineral Director: After this the Hospital or Attending Division the Funeral

> State Registrar

DHMH 17 Rev 7/2009

pleted

Medical

29a. Certifier

3 🗀 29b. Signature and title of certifie

Sandeep Sharma.

31. Date filed (Month, Day, Year) **SEP 0 9 2010**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

MD

743 Summer Walk Drive

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0064624

28f. Location (Street and Number or Rural Route Number,

Gaithersburg, Maryland 20878

29d. Date signed (Month, Day, Year)

September 7, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No.-1, Decedent's Name (First, Middle, Last) 2. Date of Death Month 09-02-2010 Physician/ Clemente Ramos 655 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Casey House 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 6. Sex 1 ፟ M 2 ☐ F 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours Min Months 11-21-1951 Honduras Yrs **Director** 214**-**08-3268 58 Usual Residence of Decedent show 10a. State 10b. County 10c, City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f 1

Yes 2 □ No MD Montgomery Silver Spring 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 11739 College View Drive 20902 Honduras hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 Married "natural", or ģ 1 🖔 Yes 2 🗆 No Specify: Honduran Maryland 21215-0036 If Yes, Give Year or Dates Specify Hispanic Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 721 (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant 6th Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked cany injury or other traumatic eve ဂ္ Clemente Pineda Jesus Ramos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juan Cedillo (Friend) 11731 College View Dr. Silver Spring, MD 20902 Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Family Cemetery 09-10-2010 Honduras 4 Donation 5 Other (Specify) 22. Name and Address of FacilitW.H. Bacon Funeral Home, 21. Signature of Funeral Service Lice Inc. 3447 14th St. N.W. Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ₽nysician: CNS Lymphoma months disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician by Physician/Medical equires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death ed by the a detached f 1 ☐ Yes 2 ☐ Unknown t een signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 \square Yes 2 \square No 3 \square Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has t e law age 2 s autopsy performed? Yes 2 A No certificate 1 ☐ Yes 2 🗓 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, it Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \bowtie Other (Specify) 1 ☐ Yes 2 🛛 No Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Hospice 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending Accident Investigation 2 Accider
3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

GR 2

State SEP 0 9 2010

Geoffrey Coleman

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D 37142

-3-2010

10-06827 Daniel Blair Rice Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1-For State Registrar Certificate	of Death		2010 g. No.	29103
Physicia Medical Exami				2. Date of Death Month September		3. Time of Death 1535 hrs
nearan Exam		Daniel Blair Rice 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
}		100 Hospital Road	Prince Frederick		Calvert	
Funeral Director		202 00 7311	If Under 1 Year If Under 24Hrs Months Days Hours Min	_	Foreign	nplace (State or n Intry) PA
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation	· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
Maryland 28a-f show any d at once,	ō	MD Calvert	Dunkirk			1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e, Street and Number	10f. Zip Code	100	g. Citizen of What Coun	try?
vith the s 23a o			20754 Vas Decedent of Hispanic Origin? (Sp	pecify Yes or No-	USA 14. Race - Americ	an Indian Black
5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho	Funeral	1 Never Married 2 X Married 1 Armed Forces? 1 X Yes 2 No	Yes, specify Cuban, Mexican, Puerto		White, etc.	
urs afte tural", aminer	d by	1 or Dates:	Yes 2 X No specify: ent's Usual Occupation (Give kind of v		Specify: whi 16b. Kind of Business/Ir	
5-0036 led within 72 hours af Hygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use reti	ired)		
within giene.	ошо	12 Journ 17. Father's Name (First, Middle, Last)	eyman Folder Oper		Printing	
21215-0036 muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C		Jessie		Brown	
MD 21215-0036 2 should be filed within h and Mental Hygiene. 27 is marked other tha matic event, the Medic		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or I	Rural Route Numb		Zip Code)
- 항목 문제			O Jewell Road, Du		1D 20754 20c. Location - City or T	Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite	1	1 Burial 2 X Cremation 3 Removal from State crematory or			Alexandria	
altin mit. P. portan ury or	1				eral Home,	
	Ц		325 Mt. Harmony L	ane, Owi	ngs, MD 20	736
Physician /Medical		23a. Fart I. Enter the disease, or complications that caused the death. Do not ente failure. List only one cause on each line.		r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular D Due to (or as a consequence of):	Isease			500.11
	پ	Sequentially list conditions, b.				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
outed nd transit						
Box 68760, e death certificate be executed the attending physician and of for use as the burial - transit	Medical	UNPENDED AMENDED				
8760, ifficate being physic as the bur			Fetal death 3 Ectopic pregna	ancy	23d. Date of delivery Month D	ay Year
Box 687 e death certific the attending r ed for use as th	Physician/	past 12 months? 4 Pregnant at time of death 5	Other (Specify)			
Ç ₽ ₽ ₽			underlying cause given in Part I.	23e. Did tob	acco use contribute to t	ne cause of death?
res that the signed by	d by			1 Yes	2 No 3 Proba	ably 4 🗸 Unknown
ords w requi	Completed			24a. Was ar autopsy	y prior to co	opsy findings available ompletion of cause of
Reco	E			perform 1 Yes 2		2 No
/ital ysician: his certifi director,	Be	25. Was case referred to medical examiner?	26.Place of Death (Check		tesidence 6 🗸 Other:	Scene
n of V ling Phys After thi funeral di	٤	27 Manner of Death 28a Date of Injury 28b Time of			ow injury occurred	
ion ttendir leath. tor: A	atior	1 V Natural 5 Pending 2 Accident Investigation (world), Day, Fear)	1 Yes 2 No			
Division of Vital Records, pital or Attending Physician: The law requir ours after death. neral Director: After this certificate has been sfilled in by the funeral director, page 2 should the control of the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director of the fun	Certification:	3 Suicide 6 Could not be determined (Specify)	eet, factory, office building, etc.	28f. Location (Str or Town, Sta	reet and Number or Runate)	al Route Number, City
Hospits 4 hours Funera ely fille		29a Centiler I I	curred at the time, date and place, and	due to the cause	(s) and manner as state	d.
To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.				
F \$ F 5	ž		29c. License number		29d. Date signed (Mon	
		ling his, vis	O.C.M.E.		September 8, 201	U
ew 15+1		So. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner	eet, Baltimore, MD 21201			
St	ate		harles			
Regist		SEP = 5 (UIU) (lever 1). A	are			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3:15 p ^D2010 Physician/ Sallv Ann Stewart sept. 6. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 213-40-7512 1 🗆 M 2 😿 F Davs (Month, Day, Year, oril 7. 1 Hours 69^{Yrs} Director April Usual Residence of Decedent show ıtal Hygiene. əd other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Silver Spring Montgomery 1 🗌 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3398 Gleneagles Drive 20906 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 X Never Married 2 Married Completed by Yes 21 No Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 🛣No Specify: 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) should be filed with h and Mental Hygien 7 is marked other th 4 Publishing Editor & Writer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William A. Stewart, II Ruth H. Hamill traumatic -Brother 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1239 Devonshire Avenue, High Point, NC 27262 Dr. William A. Stewart, III 20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State Sept 109 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring MD 20901 23a. Part 1. Enter the disease, or climit lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Bleeding disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit Severe Ulcerative Esophagitis that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Anasarca IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 2 🔀 No the 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 🔀 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or consequent within 24 hours after death.

To the Funeral Director: After this section of the funeral bird filled in by the funeral consequents. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending М 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number determined 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one)

Registrar

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) SEP U 8

Majid Rahmanian, MD

1 a Mich

32. Fegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D66372

1500 Forest Glen Road, Silver Spring, MD 20910

29d. Date signed (Month, Day, Year)

Sept. 7, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rochelle I. Stein September Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 1 □ M 2 🛛 F Months Hours Min. 1472871923 Director Yrs. 579-20-2200 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at anone. 10b. County 10c. City, Town or Location Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 306 Apple Grove Road 20904 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 N No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Senior Office Manager Be 17, Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Intrater Celia Hollander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Richard B. Stein - Son 15104 Westbury Road. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Memorah Gardens 09/08/2 22. Name and Address of Facility Hines-21. Signature of Funeral Service Licenses 111800 New Hampshire Av 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resp shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Hypoxia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): death certificate be executed sician and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 Yes 2 X No 9 Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23 Completed by Lumbar Spinal Mass Division of Vital Records, 2 has Hospital or Attending Physician: The 24 hours after death. Be 25. Was case referred to medical 26. Place of Death (Check only of Hospital: Other: 2 X No ဥ 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. D (Month, Day, Year) injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 Homicide

29a. Certifie

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Smitha Bikkaji,

lame/Relationship (Type, Print)	19b	. Mailing Addr	ess (Street and N	lumber or Ru	ural Route I	Number, City	or Town, State, 2	Zip Code)	
B. Stein - Son							Marylan		3
sposition	20b. Place of	Disposition (/ ry, crematory o	Vame of		Date		Location - City of		
5 Other (Specify)	Memor	ah Gari					ckville,		
uneral Service Licensee	1232	22. Name	and Address of	Facility Ha	ines-i	Rinald	i Funera ver Spr	ina MD	Inc. 20904
the disease, or complications that caused that failure. List only one cause on each line. (Final on	ne death. Do n XIA consequence of ITATORI consequence of	on the month of th	ode of dying, su				ver spr	Approxima	ate etween
t pregnant 23c. If yes, outcome of 1 Live Birth 2 X No 9 Unknown	Fetal death	3	ic pregnancy (specify)			_	23d. Date of d	delivery Day	Year
ificant conditions contributing to death but I Spinal Mass	not resulting i	n the underlyin	ng cause given in	Part I.	23€		o use contribute		
						a. Was an autopsy performed? Yes 2 X	prior to death?	autopsy findings o completion of ? es 2 \(\sim \text{No}\)	available cause of
red to medical Hospital:				f Death (Che	eck only on	e)			
1 X Inpatien		tpatient 3	 	☐ Nursing I			6 ☐ Other (Spe	ecify)	
th 5 Pending Investigation 28a. Date of injury (Month, Day,		ime of njury M	28c. Injury at work? 1 Yes	2 🗆 No	28d. Des	scribe how inj	ury occurred		
6 Could not be determined 28e. Place of Injury building, etc. (rm, street, fact	ory, office			ation (Street a or Town, Sta	and Number or F te)	Rural Route Nurr	nber,
1 🕱 Certifying Physician: To the best of m 2 🔲 Medical Examiner: On the basis of exa 3 🗆 Certifying Nurse Practioner: To the be	mination and/o	r investigation,	in my opinion, de	ath occurred	at the time	, date and pla	ce, and due to the	e cause(s) and m	anner stated.
title of certifier		2	29c. License num	ber		29d. [Date signed (Mor	nth, Day, Year)	
Sol Wei	M.	D.	D00	064100		S	Septembe	r 07, 2	010
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SEP 0 8 2010 32. Begistrar's	Signature .	park	1						
	ORIG	INAI							
	0.110								

3. Time of Death

1300

10d. Inside City Limits

White

1 Yes 2 X No

9. Birthplace (State or Foreign Country Illinois

2010

Montgomery

U.S.A.

Medical

10

State Registrar

Director:

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner C SANDY FROMERY non PRI ANE 9. Birthplace (State or Foreign If Under 1 If Under 24 Hrs. 8, Date of Birth 7. Age (In vrs. last birthday) Year **Funeral** Days NOV 12, Hours Year) 928 1 🗆 M 2 🔀 F Virginia 81 Yrs 579-38-0411 Director Usual Residence of Decedent 10d. Inside City Limits er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director 1 ☐ Yes 2 🙀 No Sandy Spring MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 17320 Quaker Lane #B6 20860 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black White etc ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a, Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Education Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Richard Woodward Svlvia Ridenour 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 Twinbrook Pkwy. Rockville, MD 20851 19a. Informant's Name/Relationship (Type, Print) William E. Shotts, Jr./son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Final Journey Crematory 09/04/10 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Seg Going Home Cremation Service P.O. Box 784 21029 MO1251 Reverly L. Heckrotte, P.A. MD Clarksville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 3 years Immediate Cause (Final Atrial Fibrillation Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 3 years Aortic Valve Replacement Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Directo for as a consecuence of Chronic Obstructive Pulmonary Disease 5 years physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) 3 years Physician/Medical Chronic Anticoagulation Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year for Day Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown as been signal 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? Yes 2 No page 1 Yes 2 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical director, Be Hospital 1 X Yes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 욘 eral Director; After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural Certificate: iniurv 5 Pending 2 🗌 No death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after within 24 hours a To the Funeral C Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. peted 2 <u></u> 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 3, 2010 D47682 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) 10 Bennett Morrison M.D. 2901 Olney Sandy Spring Rd. Olney, MD 20832

State

Registrar

31. Date filed (Month, Day, Ye

32. Registrar's Signature

MELLA

9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For 1 _ State	State	of Marylan		ertment of F		d Mental Hy	/giene	2010	29797
		Registrar 1. Decedent's Name (First, Middle	Last)		Cer	tificate of L	<i>Jeatn</i>	2. Date of D	Reg. No.	2010	2 J 1 U 1
Physicia Medic		Charlotte		oyer Sh	pur			Switch		2010	3. Time of Death 5:50 P M
Examin		4a. Facility Name (if not institution	give street and num			4b. City, Town, or	Location of De	n ·-		ounty of Death	
1		Montgomery Ger		oital		Olne			M	1ontgome	ry
Funeral Director		5. Social Security Number 214–12–7758	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 F Hours M	in. 8. Date of Bi	av. Year)	9. Birthp	lace (State or Foreign
		Usual Residence of Decedent		90				Mar 9	, 1920) VII	ginia
f sho	tor	10a. State 10b. County		10c. City	y, Town or Lo	cation				1	0d. Inside City Limits
Mar. 28a- notifie	Jirec		jomery		Silve	r Spring	_				1 ☐ Yes 2 🔯 No
ith the	ral	10e. Street and Number 14603 Deerhurst	•			10f. Zip Code	906			en of What Coun nited St	•
eath w ems?	Funeral Director	11. Marital Status	12. Was Dece	edent Ever in U.S	5. 13. V	Vas Decedent of Hi Yes, specify Cuba		(Specify Yes or No		I. Race - Americ	
fter de for it amine	by	1 Never Married 2 Marr	ied Armed Fo 1 ☐ Yes If Yes, Giv	2 🔀 No		Yes, specify Cuba		erto Rican, etc.)		Black, White, e	etc.
5-UU36 2 hours after "natural", o edical Exam	Completed	3 XWidowed 4 ☐ Divorced	Year or Di	ates.						oecify: Whi	
72 hc	mple	(Specify only highe	st grade completed,		(Give I	ent's Usual Occupa ind of work done of O NOT use retired)	ation luring most of v	working	16b. Kind	d of Business Inc	lustry
within giene.		Elementary/Seconday (0-12)	College (1	-4 or 5+)	Admi	nistrati	ve Assi	stant	E	ducatio	n
ytand d be filed Mental Hy arked oth	To Be	17. Father's Name (First, Middle, L	ast)				18. Mother's I	Name (First, Middle		rname)	
uld be uld be I Men marke			yer		Т		Rut				
Mal 2 sho th and 27 is r traun		19a. Informant's Name/Relationsh		-h+		g Address (Street &					
Te, 1 and f Heal ftem; other		Carolyn S. Cuth 20a. Method of Disposition	reri/daug	20b. P	lace of Dispo	Francis sition (Name of		Date Date	_	ation - City or To	
altimo rmit. Page ' partment of portant: If I y injury or ce.		1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (S				natory or other place ney Crema		/13/2010	Woo	dbine.	Maryland
DEBILITHOFE, IMBRYIGHO Z1Z13-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signary re of Funeral Service L	(10)	MOOOS							784 , MD 21029
		23a. Party Enter the disease, or	complications that	caused the deatl	h. Do not ente	r the mode of dying	necklo g, such as card	liac or respiratory a	rrest,	KSVIIIe	Approximate
Physician	83 /4	shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on ea	ach line.	A 6	- 61	· ct.	l.			Interval Between Onset and Death
Medical Examiner		resulting in death)	a. Due to	(or as a consequ	ience of):	Light	3110	, K.C			
Laminer	er	Sequentially list conditions,	b. —	(or as a consequ	Atrial	(i brill	utim				
ted nsit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	50015	(or de d'écrisequ	11	tensim					
execu an and ial-tra	Exa	that initiated events resulting in death) Last	c. Due to	(or as a consequ		16113177					
race be executed physician and the burial-transit	dica	'	d								
ertifica ding pl	/Me	IF FEMALE:	23c If yes out	tcome of pregna	nev						
death ce	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ★No	1 🔲 Live	Birth 2 Feta	ıl death 3 ⊑	Ectopic pregnanc Other (specify)	у		23	Id. Date of delive Month	ery Day Year
the de ached	hysi	9 Unknown	9 🗆 Unki	nown							
s that gned b	by	Part II. Other significant condition	ns contributing to d	leath but not res	ulting in the u	nderlying cause giv	en in Part I.				e cause of death?
duire	ted	Viabetes						_ 1 _			bably 4 🗌 Unknown
e law requires e has been sig ge 2 should b	Completed							24a. Was	yaqq	24b. Were autor prior to con death?	esy findings available apletion of cause of
n: The ficate or, pag		25. Was case referred to medical	-			00 8			ormed? 2 No	1 🗆 Yes	2 🗆 No
VICAL ysician; s certific director,	To Be	examiner? 1 Yes 2 No	Hospital:	Inpatient 2 🗆	EB/Outnation	Othe	er:	g Home 5 \square Res	idoneo 6 🗆	Other (Specify	1
og Phy ng Phy neral o		27, Manner of Death 1 Natural 5 Pendin	28a. Date		28b. Time of injury	28c. Injury work	at	28d. Describe			
VISION OF	Certificate:	2 Accident Investig	ation			M 1 🗆	Yes 2 No				
or At or At after of Direct in by	Cert	4 Homicide determ	ned 28e. Place	of Injury - At hoing, etc. (Specify)		et, factory, office			(Street and N wn, State)	Number or Rural	Route Number,
DIVISION OF VICE THE PROCESS AND THE GOOD SOLVED TO THE HOSPITAL OF A SECURITY OF THE HOSPITAL OF Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		Physician: To the b								
the Hr in 24 the Fu	Med	only one) 3 \square Certifying	xaminer: On the bas Nurse Practioner:								use(s) and manner stated.
To t To t		29b. Signature and title of certifier	m Oul			29c. License	number		0	signed (Month, L	Pay, Year) 7 2010
		20 Name and address of Marson v	who completed caus	se of death /ltam	23a) (Tuno P	rint)				/I dunai	1 & 010
15		Bichhuong M. J) in h		Prince	Philip	Mire,	Olney	, M9	2083	2
Stat Registra		31. Date filed (Morky), Day, Year)	2010 32	egistrar's Signat	A. A.	arke		3			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Frederick J. Springer 21 2010 4:54p.™ August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6804 Shenandoah Court Frederick Adamstown 8. Date of Birth (Month, Day, Yea Oct 12, 1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 XM 2 □ F Director 183-26-0349 Pennsylvania Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2X No Maryland | Frederick Adamstown 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Funeral 6804 Shenandoah Court 21710 USA . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces Health and Mental Hygiene. tem 27 is marked other than "natural", or i other traumatic event, the Medical Examin Black, White, etc. 1 X Yes 2 No If Yes, Give 10-25-1954 Year or Dates -23-1958 Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Systems Engineer</u> I.B.MBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Mary Rose Carroll Frederick J. Springer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 <u> Margaret Springer - Wife</u> 6804 Shenandoah Court, Adastown, Maryland 21710 Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 X Burial 2 Cremation 3 Removal from State any injury 4 Donation 5 Other (Specify) Saint Denis Cemetery 8-28-2010 | Havertown, Pennsylvania 21. Signature of uneral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine If any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed Dause (Disease or imjury for use as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year 1 Yes 2 No 5 Other (specify) detached ģ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by COPD 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2 s autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2**X** No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

Division of Vital Records, P.O.

State Registrar

Medical

29a. Certifier

(Check

only one)

29b. Signature and title

2 □

Yvette Warren, 31. Date filed (Month, Day, Year)

of certifier

- MID

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 3000D Ventrie Court Myersville, MD 21773

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D0058726

City or Town, State)

29d. Date signed (Month, Day, Year)

9-14-10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death September 3 2010 Year Patricia Ann Stevens Рм Physician/ 1:51 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Memorial Hospital Frederick 8. Date of Birth
(Month, Day, Year)
Dec. 6, 1945 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 🗆 M 2 🗶 F Texas Director 219-44-4550 64 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1 Yes 2 ☐ No MD Frederick Myersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15 Harp Place 21773 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces þ 1 Never Married 2 Married ☐ Yes 2 🗶 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Medical <u>Medical Coder</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Gail A. Eaton Mary Agnes Schaefer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Stevens/ Son P. O. Box # 345, Keedeysville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 9/6/10 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 21. Signature of Funeral Service Licer 22. Name and Address of Facility Robert E. Dailey & Son Funeral Homes, Fuit E Market Street, Frederick, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequent e of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (of as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ nocarcinon 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death?
1 Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ANO 1 Inpatient 2 KER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a, Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Medical 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and little of certifier 29c. License number 55/04 ws 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) main Gai 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

29d. Date signed (Month. Day, Year,

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Tsing Shen 2010 p.mM September Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 19510 Pristine Way Mary's Drayden Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months (Month, Day, Year) 08/27/1920 1 🗆 M 2 💢 F Days Hours Min Director 034-32-5907 90 China Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland St. Mary's Drayden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 19510 Pristine Way 20630 United States or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 X No ☐ Yes 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Specify: "natural", Completed Year or Dates Chinese Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. the Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ည Wei Yu Lin Tao Chen Important: If item 27 is mark any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 19510 Pristine Way, Drayden, MD 20630 Chyau N. Shen/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 and Department of h X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 09/11/2010 Leonardtown, MD Charles Memorial 21. Signature of Funeral 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield Edward N. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. heimens Immediate Cause (Final Z disensa Filysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate and Enter of the Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 for use as IE EEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No the detached 9 Unknown g Unknown Division of Vital Records, P.O. ģ Part II. Other significant condition ating to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Vunknown Completed page 2 should Cullolus 24a. Was an 24b. Were autopsy findings available has prior to completion autopsy performed death? certificate Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manny of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident within 24 hours after deat To the Funeral Director: 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, disthlucture is at the time, date and place, and due to the cause(s) and manner as static 29b. Signature an<u>d titl</u>e of certifier Three Notes DOAD, Holly wood, onde so of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month,

strar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** September 12, 2010 8:20 P M Matthew Brian Snellings /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles 3802 Brewster Circle Waldorf. 8. Date of Birth (Month, Day, Year) 11/16/1958 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 ₹M 2 ☐ F Months Washington, DC 218-66-9857 51 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Wedical Experiment cust be neithed at 1 □Yes 2 No Director Maryland Charles Waldorf 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 and hijury or other traumatic event, the Martiness 2.3a or 2 once. 20601 United States 3802 Brewster Circle Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1∐Yes 2XNo White Specify: Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Government Information Security officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George H. Snellings, III Mary Femiano ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dana J. Snellings/Wife 3802 Brewster Circle, Waldorf, MD 20601 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cem. 9/15/2010 Bryantown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Funeral Service Licensee NOIL M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ance **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 No 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only on Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Deatl 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1-Natural 5 ☐ Pending investigation 1 ∐Yes 2 □ No nours after death.
neral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Funel

completely fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifier 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 32/ Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

2010 29792 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month 1803 hrs Madical Examiner September 11, 2010 Clare Stoudt 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3762 Bonny Bridge Place Ellicott City Howard If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Maryland Director Months Days Hours Min. June 16, 1975 218-98-8894 1 M 2 X F 35 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Marvland 28a-f shov Howard Ellicott City Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Heath and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10g. Citizen of What Country? 4395 Montgomery Road USA 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White, etc. 1 Never Married 2 Married Yes 2 X No 3 Widowed 4 X Divorced 1 Yes 2X No specify: If Yes, Give Year Specify: White ۾ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Law Firm Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stoudt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Stoudt/Father 39572 Walnut Circle, Mechanicsville, MD 20659 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 09/18/2010 Queen of Peace Helen, Maryland Donation 5 Other Specify ²² Name and Address of Facility
Brinsfield-Echols Funeral Home, P.A.
30195 Three Notch Rd., Charlotte Hall, Signature of Funeral Service Licenses MOO817 MD 20621 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Retween Onset and Medical Death a Multiple Shotgun Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signed by should be detach ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has page 2 performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. Be Hospital: 1 Inpatient 2 Other4 this Nursing Home 5 Residence 6 🗸 Other: Scene DOA ER/Outpatient 3 ဥ 1 V Yes 28a. Date of Injury FOUND: After 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject shot FOUND: Natural Pending 1 Yes 2 ✔ No Director: Sep 11, 2010 1800 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 3762 Bonny Bridge Place , Ellicott City, MD determined (Specify) Townhouse / Rowhouse the Funeral 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number September 12, 2010 O.C.M.E. 30. Name and address of person, completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 32 Registrar's Signature State Registrar

amended 10c/9/08/2010/wchd/map

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Veronica Smith	

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Division of Vital Records, rate of Attending Physician: The law requirers after this certificate has been sited in by the funeral director, page 2 should b	Certification:	dete	ld not be mined 28e. Pla	ce of Injury - At h	ome, farm, stree	et, factory, o	office but	iding, etc.	2	or Town, S		Number	or Rura	I Route Number, City
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To To	Mec	29b. Signature and title of certifie	and manner	stated		29c.	License i	number			29d. Dat	e signed	(Monti	n, Day, Year)
			M1	1			O.C.M	.E.			Augus	t 27, 2	010	
		30. Name and address of person	who completed cau	se of death (Item										
- <u> </u>		Jack Titus MD. Der	outy Chief Medi			n Street	, Baltir	nore, M	D 212	01				
S: Regis	ate	31. Date filed (Month, Day, Year)	32:-R	egistrar's Signati	La Kel									

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:25AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** othern Marghad Hospita INCE ears 101 If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Min. (Month, Day, Hours **Director** Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at. within 72 hours after death with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d, Inside City Limits Director 1 🗆 Yes 2 🗶 No MONC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23832 Or 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes Give 3 Widowed 4 ☐ Divorced lack Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. hemical HOSP permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt once, Be 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Smith 20a. Method of Disposition 20b. Place of Disposition (Name o 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) -13-10 South FUNERAL FEGGINS 21. Signature of Funeral Service License 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysiciani disease or condition Medical resulting in death) Examiner いつついノイ Sequentially list conditions, if all y, leading to immediate cause. Enter Underlying Examiner burial-transit Cause (Disease or iinjury that initiated events and resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 24 hours after death.

Funeral Director: After this certificate! 2 No Yes 1 🗌 Yes within 24 hours after death.

To the Funeral Director, After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ Nation 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Natural Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) e of death (Item 23a) (Type, Print) SEP 0 9 2010 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 750 Medical 4a. Facility Name (if not institution, give street and numbe Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 8 Decatur Avenue Annapolis If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)Germany 1 🗆 M 2 🗸 Months Hours 1070771922 Director 173-26-3148 87 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Annapolis 1 🗆 Yes 2 🖺 No Maryland Anne Arundel 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 21401 United States 803 Coxswain Way, Apt. 105 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 ♥ Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Meat Packing Butcher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Martha Lorenz Alfred Koch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gitta S. Humphreys/Daughter 8 Decatur Avenue, Annapolis, Maryland 21403 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Kalas Crematory 09/16/2010 Edgewater, Maryland Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 2973 Solomons Island Road, Edgewater, MD 21037 234. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death STROKE Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After the continuous process. within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Dav Year 9 Unknown ☐ Hnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4RTER 1 Ses 2 No 3 Probably 4 Unknown ETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 2 1 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 **P**No ျ 1 Tyes DAUGHTER'S 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Sther (Specify) 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ TANTCE THOMPSON rotembe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death LANHAM COMMUNITY PRINCE GEORGE'S HOSPITAL DOCTORS Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 6. Sex Age (In yrs. last birthday) 1 M 2 SZ F Hours 9 /237 1939 Washington, DC Director 579-54-2310 70 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No Maryland Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20746 5765 Suitland Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married "natural", or Completed by 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic exceptions. Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Coordinator Dept. of Labor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Excell Sneed Mabel B. Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5765 Suitland Rd. Suitland, Maryland 20746 James L. Thompsom / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland National 9/10/2010 Laurel, Maryland Signature of Funeral Service L 22. Name and Address of FacilityPope Funeral Homes, P.A. Dange 0101085 5538 Marlboro Pike Forestville, Maryland 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner OBS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death detached 9 Unknown 9 Unknown P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, The law requires NEUMONIA 3 Probably 4 ☐ Unknown Completed 1 Tyes 2 🗌 No page 2 should HYPERTENSION ULMONARY 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perform certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Inpatient 2 I ER/Outpatient 3 I DOA this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work? 1 Yes 2 No 24 hours after death Funeral Director: A Investigation 6 Could not be 2 Accident completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Set trying Prijordian. To the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) 29b. Signature and title of certifier 30. Name and address of person completed cause of death (Item 23a) (Type, Print) LANHAM, ND 20106 4000 .

State Registrar 31. Date filed (Month, Day, Year)

SEP 0 9 2010

32. Registrar's Signatur

	4	_ State	_	artment of Health ar <i>tificate of Death</i>		0010	00700
		1. Decedent's Name (First, Middle, Last)	<u> </u>	tineate or beating	2. Date of Deat		3. Time of Death
Physicia Medic		Jogn Uddeck			September 1		5:00 A M
Examin	er	4a. Facility Name (if not institution, give street and nui 1905 Hickory Hill Lane	nber)	4b. City, Town, or Location of Silver Spring		4c. County of Deat Mon tgome i	
Funeral Director		5. Social Security Number 6. Sex 1 G M 2 屎 F	7. Age (In yrs, last birthday) 79 Yrs.	If Under 1 Year If Under 24 Months Days Hours	Min. May 12,	9. Bird Penr	thplace (State or Foreign untry) 15y1vania
aryland a-f show lied at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgomery	10c. City, Town or Loc Silver S				10d. Inside City Limits 1 ☐ Yes 2 🌁 No
vith the Me 23a or 28s st be noti	Funeral Director	10e.Street and Number 1905 Hickory Hill Lane		10f. Zip Code 20906	i	l 0g. Citizen of What Co USA	ountry?
Baltimore, Maryland 21213-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	Armed F	orces? I 2 🖾 No ve 1	Mas Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, I I Yes 2 XXII Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
Z15-UU30 in 72 hours after e. nan "natural", o	Completed	15. Decedent's Education (Specify only highest grade completed	(Give	dent's Usual Occupation kind of work done during most o O NOT use retired)	- 1	16b. Kind of Business	
VIZ within giene. er thai		Elementary/Seconday (0-12) College (oyment Counseld		Temporary	Employment
land be filed ental Hy rked oth	To Be	17. Father's Name (First, Middle, Last) Gabe Kennedy			s Name (First, Middle, M ry Turnbach		
Maryland 2 should be filed Ith and Mental Hy 27 is marked oth		19a. Informant's Name/Relationship (Type, Print) Joseph C. Undeck / Hush	and 196. Mailir	ng Address (Street and Number 5 Hickory Hill	or Rural Route Number, Lane, Silv	City or Town, State, Zi er Spring,	² MD ^{e)} 20906
altimore, rmit. Page 1 and partment of Hea portant: If Item y Injury or othe		20a. Method of Disposition 1 第78Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)		osition (Name of matory or other place) Ser wen Cemetery 20	otember 10, 10	20c. Location - City or ilver Spri	
balt permit. Depart Import any Inji		21. Signature of Funeral Service Licensee	22	Name and Address of Early Francis 500 University	lins Funera Blvd., W.,	1 Home, In Silver Sp	c. ring, MD 20901
Physician/		23a. Part 1. Inter the disease, or complications that shock, or heart failure. List only one cause on e	caused he death. Do not entreach line.		ardiac or respiratory arre	est,	Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)	(or as a consequence of):	ctive Lung Dis	ease		10 Yrs.
	iner	cause. Enter Underlying	o (or as a consequence of):				
Box 68 760 death certificate be executed ne attending physician and ed for use as the burial-transit	cal Examiner	Cause (Disease or iinjury that initiated events C.	o (or as a consequence of):				
ficate b g physias the t	Medical	d					
ital Records, P.O. Box 687 ioian: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as	Physician/M	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of de Month	elivery Day Year
cords, P.O. law requires that the nas been signed by the 2 should be detach	ρ	Part II. Other significant conditions contributing to	death but not resulting in the (underlying cause given in Part I.		bacco use contribute to	o the cause of death? Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requires is after death. al Director. After this certificate has been signed in by the funeral director, page 2 should be	Completed				24a. Was a autop perfor	sy prior to med? death?	utopsy findings available completion of cause of
tal R	Be C	25. Was case referred to medical examiner?		26. Place of Death		2 13 10	2 2 110
of Vil	은	1 Yes 2 KNO 1 27. Manner of Death 28a. Dat	Inpatient 2 ER/Outpatie e of injury 28b. Time o enth, Day, Year) injury	f 28c. Injury at	sing Home 5X Resid	ence 6 COther (Spe ow injury occurred	cify)
tending death. tor: Afte the fun	Certificate:	2 Accident Investigation	onth, Day, Year) injury ce of Injury - At home, farm, sti	M 1 Yes 2 1		treet and Number or Ri	ural Boute Number
Divis tal or At rs after al Direc ed in by		4 Homicide determined 206. Flat built	ding, etc. (Specify)	eet, factory, office	City or Tow	n, State)	arar risato riamosi,
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Medical	29a. Certifier (Check (Check only one) (Check only one) (Check only one)	asis of examination and/or inves	stigation, in my opinion, death occ	curred at the time, date a	nd place, and due to the	cause(s) and manner stated.
To th within To th		29b. Signature and the of certifier) Me	29c. License number D03792		29d. Date signed (Mon September	th, Day, Year) 7, 2010
		30. Name and address of person who completed ca Irnest S. Oser, MD 103	use of death (Item 23a) (Type.	Print) e., Ste. 304, S	S.S., MD 20	902	
Sta Registi			Registrar's Signature				

			For State Registrar	State of	Marylan	-	artmen tificate			and M	lental Hy	giene Reg. No	010	29800
	Physicia	n/	1. Decedent's Name (First, Midd Doris An								2. Date of Dea Month Septem	th Day	2010	3. Time of Death
	Medic Examin	al	4a. Facility Name (if not institution		er)		4b. City,	Town, or I	ocation of	of Death	Septem		unty of Death	23:04 M
	LXaiiiii	e.	Shady Grove A					ckvi					Montgo	mery
161	Funeral Director		5. Social Security Number 579–42–6122	6. Sex 1 □ M 2 🗹 F	Age (In yrs. la	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Feb. 1	h <i>, Year)</i> 4 1933	Coun	place (State or Foreign try) ryland
	show show	or	Usual Residence of Decedent 10a. State 10b. Count	у	10c. Cit	y, Town or Lo	cation						1	10d. Inside City Limits
	Maryla 28a-f	Director	Md. M	ontgomery		Gait	hersb	urg						1 🗗 Yes 2 🗆 No
	th the 3a or the n	ral D	10e. Street and Number 6 James Stree	t			10f. Zip	Code 208	77				of What Cour	
	ems 2	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S	S. 13. V	Was Decede			gin? (Spe	cify Yes or No- Rican, etc.)	-	Race - Americ	
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0000	ours a	Completed	3 Widowed 4 Divorce	ed Year or Date	s.									nite
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ylallu	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Reuben Cole	*						er's Name seph	ine Dy		name)	
, Mar	nd 2 shou ealth and m 27 is m ier traum		19a. Informant's Name/Relation		ınd						Route Number hersbur	g, Md	. 2087	77
2	ge 1 and it of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	n 3 🗌 Removal from S	tate c	lace of Dispo emetery, cren	natory or ot	her place			Date		ion - City or To	!
Daltimor	nit. Pa artmer ortant injury		4 Donation 5 Other 21. Signature of Funeral Service		For	est 0a			-		8/10			irg, Md.
٥	permit Depar Impor any in once,		Day w	Barba	1		Muri P. C	el E	l. Ba Sox 5	rber 038.	Funera Layton	1 Home sville	e e, Md.	20882
	Physician/ Medical Examiner	her	23a. Part 1. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Au Tue to (or b.	used the death line. Non av as a consequence as a conseq	emb uence of):	oclisi	n	, such as	cardiac o	r respiratory am	est,		Approximate Interval Between Onset and Death
3	s be exysiciar ysiciar e buria	edical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):								
DO YOU .	ne death certifi / the attending ched for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		rth 2 ☐ Feta nt at time of c	Ideath 3	Ectopic p Other (spe					23d	. Date of deliv Month	ery Day Year
5	that the ned by e deta	by P	Part II. Other significant condit	tions contributing to dea	th but not res	ulting in the u	inderlying c	ause give	n in Part	l.	23e. Did to	bacco use c	contribute to tl	ne cause of death?
colds,	equires en sig ould b										1 🗆 '	res 2□N	lo 3 🗆 Pro	bably 4 🗹 Unknown
משנים ו	The law re cate has be page 2 sh	Completed									24a. Was a autop perfo 1 Yes	rmed?		psy findings available mpletion of cause of
9	ician; certific ector,	Be	25. Was case referred to medica examiner?	Hospital:				Other			only one)			
> 5	Phys or this eral dir	e: 10	1 ☐ Yes 2 ⚠ No 27, Manner of Death	1 ½ In 28a. Date of	patient 2 🗆 injury	28b. Time of		A Injury	4 ∟ Nı		me 5 Resid			9
5	anding sath. rr: Afte	icat		tigation	Day, Year)	injury	м	work?				, , , , ,		
	tal or After or after de al Directo	27. Manner of Death Yes 27. Manner of Death 28d. Date of injury 28d. Date of injury 28d. Describe how injury occurred 28d. De										Route Number,		
	he Hospi iin 24 hou he Funera ipleted filla	29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.										use(s) and manner stated.		
	Vith Com													
			30 Name and Adding on	m.D.	of docth /u .	220\ 75: 5		00	65 5	05		Sep	Lember	J, 2010
•	10		30. Name and address of person Qiufang Cheng					er I	rive	, Ro	ckville	, Md.	2085	0
	Stat Registra		31. Date filed (Month, Day, Year)	7 20 0 D	istrar's Signat	ure A.	par	1						

DHMH 17 Rev 7/2009

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Sept. 2, 2010

BORIS WALKER

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Olato of marylans	Cei	rtificate of	Death	Reg	. No.	
			1. Decedent's Name (First, Middle, Last)					Date of Death Month	Day 20 Year	3. nof Dan
	Physicia /Medic		Jack Franc	is Witten					r 3, 2010	2:00 p. M
- 3	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death		4c. County of Deat	
-			St. Mary's Hospi	tal			rdtown		St. Mar	
	Funeral		5. Social Security Number 6. Sex		• • • • • • • • • • • • • • • • • • • •	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y	(ear) Co	hplace (State or Foreign untry)
	Director		325-18-0225	92	Yrs.			03/25/19	18	Illinois
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	ocation				10d. Inside City Limits
	laryli sho	5								1 ☐ Yes 21X No
	the N	Director	Maryland St. Ma 10e. Street and Number	ry's	Great	M1LLS 10f. Zip Code		100	a. Citizen of What Co	untry?
	with ta or			Darizzo		206			USA	
	eath	Funeral	45895 Stoney Run	12. Was Decedent Ever in U.S	S. 13.		Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
10	fter d	ᠴ	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 X Yes 2 ☐ No				Rican, etc.)	Black, White	e, etc.
036	al",o	þ	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 🛣 No	o Specify:		Specify:	White
21215-0036	is and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. If Health and Mental Hygiene. Other traumatic event, the Medical Evanther rough to notified and other traumatic event.	Completed	15. Decedent's Edu (Specify only highest grad	cation		dent's Usual Occ	upation e during most of work		6b. Kind of Business/	Industry
21	within 7 iene.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	`life.	DO NOT use retir	red)		U.S. Navy	
21	filed wi Hygier other the	ပ္ပ	12		Log.	istics E			<u>-</u>	
pu	oe filed tal Hygi d other event,	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma		
yla	2 should be f and Mental is marked o 'aumatic eve	ပ		ten			France		een	7. 0. / 1
	2 sh and is m	10	19a. informant's Name/Relationship (Ty	•	1		et and Number or Ru			
	1 and 2 Health em 27 i		Robert H. Witten				Avenue,		oc. Location - City or	
Ore	ges 1 a t of Hea If item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	temoval from State	-	osition (Name of matory or other p	i		•	
ᆵ	t. Pa tmen tant: tant:	١,	4 □ Donation 5 □ Other (Specify)			n Nation			Arlington	
Baltimore,	permit. Pages 1 Department of I Important: If ite any injury or of		21. Si natura de neral Service Licens				Iress of Facility Br			
	TO = # 0		Edward N. Brins 23a. Part 1. Enter the disease, or compl							
,		2 105	shock, or heart failure. List only of	ne cause on each line.	n. Do not en	2001	1.0 -1		o.,	Approximate Interval Between Onset and Death
	Physician	ľ	Immediate Cause (Final disease or condition resulting in death)	2.	vatro.	n Myacu	Ida into	arotzon:		
7	/Medical Examiner		and the second s	Due to (or as a consequence	uence of):	τ.				
		<u>.</u>	Sequentially list conditions,	Due to (or as a x nseq	uence of):) (2 ·				
	uted nsit	ij	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Quant Pa	ilura					
	execu n and al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
68760,	rtificate be executed ng physician and as the burial-transit			1.						
.89	tificat g phy as the	Medical								
		-	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	ancy	☐ Ectopic pregna	anov.		23d. Date of de	
	0 0 0	icia	in the past 12 months? 1 □Yes 2 □No	4 ☐ Pregnant at time of c		Other (specify)			Month	Day Year
P.0.	law requires that the de as been signed by the a 2 should be detached f	Physician/	9 ☐ Unknown							- Alexander of deaths?
S,	as the gned se de	by F	Part II. Other significant conditions co				given in Part I.			o the cause of death?
D.C	w require s been si should t	pe	- Ohemia	· ·		··		1 Li Yes		robably 4 Unknown
မင္ပ	e law r has be e 2 sh	Completed						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
<u></u>	ate yag	Ö						perform 1 □ Yes 2	ed⊮ i deatn?	s 2□No
/ita	Physician: The ribis certificate had director, page	Be (25. Was case referred to medical examiner?			1.		th (Check only one)	
<u></u>	Physic this c	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐		SIL S L DOA			nce 6 ☐ Other (Sp.	ecify)
n O	ing P	ü	27. Mann of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury		njury at Vork?	28d. Describe how	w injury occurred	
Sic	Attending r death. sctor: After by the funer	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	On Place of Injury. At h	ama farm of		□Yes 2□No	29f Location (Str.	eet and Number or F	Rural Route Number
É	or A	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Special	fy)	treet, lactory, offic	e.	City or Town,	State)	in a rioute rearries,
1	Hospital 24 hours a Funeral I tely filled		29a. Certifier 1 ☐ Certifying Phy	sician: To the best of my kno	owledge, dea	ath occurred at the	e time, date and place	l e, and due to the ca	ause(s) and manner	as stated.
		<u>.</u> ~	(Check only 2 Medical Exam	iner: On the basis of examina and manner stated.	ation and/or i	Investigation, in m	y opinion, death occi	urred at the time, da	ate and place, and du	e to the cause(s)
	e Ho 1 24 h e Fu	Q	one)	and mainter etated						
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29b. Signature and title of certifier	111		29c. Lice	ense number	29	d. Date signed (Mor	th, Day, Year)
	To the Ho within 24 I To the Fu completely	Med		41.h. ME	. .	29c. Lice	ense number 604 7-3	29	Deptember	oth, Day, Year) -/03/2010
		Med		46h. ME		D c	060473	1 29 d	Deptember	nth, Day, Year) -/03/2010
ku		Med	29b. Signature and title of certifier Muchn S All	46h. ME	anyis	Do	060473	town n	Deptember ND 200	nth, Day, Year) -/03/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Of Mar State Registrar		rtificate of L		nentai myg	leg. No. 20	10	29802
	Physicia		1. Decedent's Name (First, Middle, Last) David Dean Walden				2. Date of Deat			3. Time of Death 11:20A M
	Medic Examin		4a. Facility Name (if not institution, give street and number)			Location of Death		4c. County	of Death	1 - 1
مجمدي	Funeral		5405 Rapidan Court 5. Social Security Number 6. Sex 7. Age (1	In yrs. last birthday)	Lothian If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		g. Birthp	place (State or Foreign
	Director		459-66-9460	Yrs.	Months Days	Hours Min.	9/27/19	39	0klar	ioma
	yland -f show ed at	ctor	10a. State 10b. County 1	10c. City, Town or Lo	ocation			_	1/	0d. Inside City Limits
	he Mar or 28a e notifi	Dire	Maryland Anne Arundel 10e. Street and Number	Lothian	10f. Zip Code			10g. Citizen of W	Vhat Coun	
	h with t ns 23a nust be	Funeral Director	5405 Rapidan Court		20711			USA		
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. The teath and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Everories Armed Forces? 1 □ Yes, 2 ▼ Note of the Service of	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		ecify Yes or No- Rican, etc.)	Blac	e - America k, White, e Whit	etc.
15-(72 hou n "nat fedica	nple	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done of OO NOT use retired)	ation luring most of work	ing	16b. Kind of Bu	siness Ind	lustry
212	I within ygiene. her tha ht, the I	e Co	Elementary/Seconday (0-12) College (1-4 or 5+) 5+	CPA				Account	ting	
and	be filed ental H ked ot ic even	To Be	17. Father's Name (First, Middle, Last) Dennis D. Walden			18. Mother's Nam Ora A. I		Aaiden Surname)	
lary	should and M is mar		19a. Informant's Name/Relationship (Type, Print)		ing Address (Street a	and Number or Rura	al Route Number,	-		ode)
é, ≥	and 2 Health tem 27 other tr		Susan L. Walden/Wife 20a. Method of Disposition	20b. Place of Dispe	Rapidan osition (Name of		othian,	MD 2071: 20c. Location -		wn. State
Baltımore,	Page 1 ment of ant: If i		1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Kalas Ci	matory or other place rematory	e) 8/31			•	Maryland
Balt	permit. Page 1 a Department of H Important: If ite any injury or ot once.		21. Signatury 1 Funeral Service Licensee	2	2. Name and Addres	ss of Facility Geo Mons Isla	rge P. k	Kalas Fu Edgewate	inera	1 Home 21037
	Trysician/	6 0	23a. Part 1. Enter the disease, or complications that caused the shock, or Ifeart failure. List only one cause or each line. Immediate Cause (Final disease or condition		ter the mode of dyin					Approximate Interval Between Onset and Death I + M 0)
-	Medical Examiner		resulting in death) Due to (or as a c	onsequence of):						
	ed ssit	Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a cause. Enter Underlying Cause (Disease or imijury)	onsequence of):						
	e execut cian and urial-trar	al Exa	that initiated events c. The property of the	onsequence of):				<u>-</u>		
2/60	ficate b g physi as the b	Nedic	d							
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. Within 24 hours after death. Completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown 23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at ti g ☐ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	у		23d. Dat Moi	e of delive	ery Day Year
0.	s that the general by se detail		Part II. Other significant conditions contributing to death but	not resulting in the	underlying cause giv	ren in Part I.				ne cause of death?
ords	require been si should I	leted					1 X Y			oably 4 Unknown
Division of Vital Records,	The law ate has page 2 t	Completed					autops perfor	sv p	orior to cor death?	mpletion of cause of
Ta	ician: certific ector,	Be	25. Was case referred to medical examiner? [Hospital:		26. Pl	ace of Death (Chec	k only one)			
ot v	g Phys er this eral dir	te: To	1 ☐ Inpatient 27. Manner of Death 28a. Date of injury	t 2 ER/Outpatie 28b. Time o (ear) injury	nt 3 □ DOA DOA 28c. Injury	4 ☐ Nursing Ho	me 5 Reside 28d. Describe ho		//	
Sion	ttendin death. :tor: Aff / the fur	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	- At home, farm, sti		Yes 2 □ No	28f. Location (St	irant and themba	on on Dunal	Pauta Alumbar
N N	rtal or A rs after ral Direct led in by		4 Homicide determined 26e. Place of injury building, etc. (Specify)	reet, factory, office		City or Town		r or nurar	noute Number,
	n 24 hou e Funer	Medical	29a. Certifier (Check conly one) 2 Medical Examiner: On the basis of examonly one) 3 Certifying Nurse Practioner: To the be	mination and/or inves	stigation, in my opinio	n, death occurred a	the time, date an	d place, and due	to the cau	use(s) and manner stated.
		_	29b. Signature and title of certifier	L_	29c. License		2	29d. Date signed	(Month, E	
	的的		30. Name and address of person who completed cause of deal	th (Item 23a) (Type,			Anno	1 -		21401
	Stat	е		Signature	6.1010	, 4,7	111110VIA	0013 116) (71701
	Registra	ır	JET V 4 ZUIU	w B. A	ave					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 2, 2010 Hazel G. Willard 2:26 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Year) 1 🗆 M 2 🔀 F Alabama Director 84 578-28-8188 1926 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Edgewater 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 2613 Commander Davis Drive 21037 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eugene Lee Howard Hazel Stella Dean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin P. Willard / 1920 Stanford Court, Landover, Maryland 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🖪 Burial 2 🗆 Cremation 3 🗆 Removal from State Mt. Olivet Cemetery 9-8-2010 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Fundral Service 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 lart 1. For the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 To
9 Unknown Month 5 Other (specify) Day Year Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 1 Tyes 3 Probably 4 Unknown been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific. 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1Scrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month

30. Name and address of person who completed cause of death/(tem 23a) (Type, Prin

SEP 0 7 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Evelyn Wren September 2010 Δ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6409 Hil-Mar Drive 102 <u>District Heights</u> Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days (Month, Day, Year) 02/28/1928 Hours Min. Country 1 M 2 X F 82 Director <u>579-38-4489</u> Motte.S.C 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Md. P.G. 1 X Yes 2 No District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Funeral or items 23a 6409 Hil-Mar Drive # 102 20746 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 hours after 1 Yes 2 No Specify. Africannit. Page 1 and 2 should be filed within 72 hours aft rartment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Exar If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Domestic Worker <u>Private Homes</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Adam Zeighler Addie Mae Gold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda L. Wren/Daughter 520 46th St., S.E. # 2, Washington, D.C. 20019 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial ② ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory, Inc. 09/04/10 Beltsville, Maryland 22. Name and Address of Facility
Henry S. Washington & Sons Co., Inc. 21. Signature of Funeral Service Licenses any 4925 Burroughs Ave., N.E., Washington, D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebrovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Cardiac Arrhythmia if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and if for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year led by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ Records, or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Dementia Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Arthritis has performe 1 🗌 Yes 2 🗆 No Yes 2 No Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider (Month, Day, Year) 5 Pending work? n 24 hours after death.

e Funeral Director: Aipleted filled in by the fu death. 1 Tes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I complet 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 09/03/10 D00030296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Registra Signat re

5100 Auth Way, Suitland, Maryland

Deborah M. Thompson, M.D.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Addison - McNeil 2 1 7 , 2 9 1 0 Physician/ SEPTEMBER Donise 10:50P^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON GREATER BALTIMORE MEDICAL CENTER Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 218.54.4200 (Month, Day, 1 M 2 X F Months Hours MD Director Usual Residence of Decedent MCNEIL YVONNE or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Ba Himone Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a Triple (izwn) 744 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Black If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry
Battmore County 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Guidance Counselor 12th grade 5+ years should be filed very and Mental Hyg 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wendell Addison McCaden Dotores 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Crown Court rank T. McNeil Baltimone, ND 21244 Iriple Husband Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
VVOCALAWN CEMETERS 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Intoglawn, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Vallahin C. Greene Filmoral services augh 18 Liberty Road Candellotoun ND 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as eardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ ardiocenic day Medical resulting in death) Examiner 3 muoco rdia ute Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine physician and the burial-transit requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last troin Due to (or as a consequence of) attending physician Physician/Medical Records, P.O. Box 68760 SB for use If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Day Year should be detached Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ischemic 24a. Was an the Hospital or Attending Physician: The law page 2 s has performed' Chronic renal tailur this certificate 1 Yes 2 No 2 🔼 Division of Vital 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ဂ္ 1 Npatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After 1 Natural 2 Accident (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 1 🔽 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day. Year) Chathen Marie D2090. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St 6701 N

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

SEP 2 3 2010

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 100 Wedgemont Drive Elkton Cecil If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 395-58-2003 Months Days Hours Min. (Month, Day, 58 Director 05/19/1952 Usual Residence of Decedent 28a-f show 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Cecil MD Elkton 1X Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 100 Wedgemont Drive 21921 USA items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Allen John Lois Brussius 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
100 Wedgemont Drive, Elkton, MD 21921 Robert Odle / Spouse 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛭 Cremation 3 ☐ Removal from State 9/22/2010 4 Donation 5 Other (Specify) Final Journey Crem. Woodbine, MD 22. Name and Address of Facility Cremation Services 21203 Signature of Funeral Service Licenses Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Bre Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to lor as a consequence of Examiner Sequentially list conditions Examine cause. Enter Underlying Cause in the Underlying Due to for as a consecuence on use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? ò Month Day Pregnant at time of death the detached 9 Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? 1 Yes 2 No Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\to\) Nursing Home 5 \(\to\) Residence 6 \(\to\) Other (Specify) 2 **N**O ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral (28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 \square Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

To the

only one

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who comple

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DHMH 17 Rev 7/2009

ted cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 14 Physician/ Month Medical 4a. Facility Name (if not institution, give street and number Town, or Location of Death 4c. County of Death Examiner Northwest Seasons Hospice Baltimore Randallstown Social Security Number 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) Funeral Days Hours Min (Month, Day, Year) 1 M 2X F Months 216-80-0551 49 Yrs Director SC Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho idical Examiner must be notified at 10d. Inside City Limits Director MD 1 X Yes 2 No NA Baltimore 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 2757 Winchester Street 21216 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. African 1 XNever Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: American Completed 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Dept. of Motor Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) Clerk 2vrs. Vehicle t. Page 1 and 2 should be filed wi rtment of Health and Mental Hygie rtant: If item 27 is marked other njury or other traumatic event, ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wilbur Bellamy Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma Bellamy-Mother Winchester Street Baltimore, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date cemetery, crematory or King Mem. er place) 1 X Yourial 2 Cremation 3 Removal from State 09-25-10 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 21. Signature of Funeral Suice Lanse. 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Liner underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) the detached 9 Unknown g 🗌 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signe page 2 should be 1 Yes 2 No 3 Probably 4 Punknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 X No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Tyes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Natural 5 \square Pending injury Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

			- State Amend Item 17 St	ate of Maryland of Personal Cer	ytnent of Health and N tificate of Death	Mental Hygien Reg. N	e.2010	29809
			Decedent's Name (First, Middle, Last)	0		2. Date of Death		3. Time of Death
	Physicia Medic		Alisher Band			Month 9	Day 18 Year 10	8:26PM
	Examin		4a. Facility Name (if not institution, give street	and number)	4b. City, Town, or Location of Death	4	c. County of Death	
			University of Mas	Word Med	Baltimore	2	NIA	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birthpla	ce (State or Foreign
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	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral		ne Road	2/229	Un	ited ste	2725
	r dea iner		Λ,	mod Forces?	Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - American Black, White, etc	
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7	withi giene er th , the		12	Sec. 190	curity Ofice	200	Se Luno	ty
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<u>Ja</u>	d be Ment arke	입	Bennett Blu	rdock	Mari	1 /104	d	
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Pri	nt) 19b. Mailin	g Address (Street and Number or Rur	al Route Number, City	or Town, State, Zip Co	de)
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ore	of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo	20b. Place of Dispo	sition (Name of patory or other place)	4	Location - City or Tow	l a
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<u>sio</u>	Atten r dea ctor: y the	Certificate:	3 Suicide 6 Could not be	e. Place of Injury - At home, farm, stre		28f. Location (Street a	and Number or Rural F	Route Number,
Division of Vital	al or safter		4 Homicide determined	building, etc. (Specify)		City or Town, Sta		
_	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		To the best of my knowledge, death o				
	he Ho in 24 he Fu plete	Mec		n the basis of examination and/or invest ctioner: To the best of my knowledge, o				
	To t with To to		29b. Signature and title of certifier		29c. License number	29d. E	Date signed (Month, Da	ay, Year)
			I lesabeth Keco	abono Do			9/18/2010	0
			30 Name and address of person who complete	ted cause of death (Item 23a) (Type, P	rint)			
			Elizabeth Ricco	bono uain	rint) C 725. Gree	ne St	Baltim	ove MI)
	Stat		31. Date filed SEP 2 3 2010	2. Registrar's Signature	Ke			-
	Registra	ir	721 NO 2010	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 50Pt Hattie Louise Brown 2010 5:56 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City Baltimore** Levindale Hebrew Geriatric Center & Hospital 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Min. Hours Country) 218-28-1808 MD Director Aug 4, 1930 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director **Ellicott City** 1 Yes 2 No MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 3008 Westchester Ave. 21043 U.S.A. be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11 Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other tran "na any injury or other traumatic event once. Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping Supervisor **Food Service** 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Plunkert Vera Estella Koontz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry McDonald 164 Carnival Dr. Taneytown, MD 21787 daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State **Good Shepherd Cemetery** Sep 25, 2010 Ellicott City, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 21. Signature of Funeral Service Li 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line. er or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Sepsi Physician/ disease or condition resulting in death) a46 Medical Examiner intection 945 Sequentially list conditions Examine if any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury signed by the attending physician and defacthed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this conditions. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by congest 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other: 2 X No 1 🗌 Yes ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examination and/or inventionable in a stated. Medical 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2' Medical Examiner: On the pasts of examination already investigation, it may operated at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

2434 W . (31. Date filed (Month, Day, Year)

was of person who completed cause of death (Item 23a) (Type, Print) SURALYAW, BELVEDERE AVENUE PALTIMORE

D0053928

BELZUM MD-2 2010

21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#5perFH, G907, 9/28/2010, WS
State of Maryland / Department of Health and Mental Hygiene
State of Maryland / Department of Health and Mental Hygiene

amend #23e626 Per PHy G908 10/08/10 JH

Certificate of Death

Reg. No. Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER 21 2010 5:50 P M STEPHEN KEITH BRADLEY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign 1 ፟M 2 □ F Months Days Hours Feb. Py Year 1956 Michigan 54 Director 28a-f shov 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🖺 No Maryland Harford Abingdon 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2937 Ruskin Court 21009 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other tl Medical Center Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Raymond Bradley Jr. Martha Lorine Runkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2937 Ruskin Ct., Abingdon, Maryland 21009 Rachel Bradley / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp: 9-23-10 Towson, Maryland 21. Signature of Fineral Sy Licensee McComas Funeral Home, P.A. 1317 Cokesbury Roaf, Abingdon, MD 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicians Muttiorgan disease or condition resulting in death) system failure Medical Due to (or as a consider of): Examiner REtractory Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine use as the bunal-transit Cause (Disease or liniury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ó 5 Other (specify) Month Dav Year 1 Yes 2 9 Unknown should be detached 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Heratitis 1 Yes XX No 3 Probably 4 Onknown Completed Circussis & liver 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 ☐ Yes 2 ☑No 25. Was case referred to medical Division of Vital or Attending Physician: Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) ည Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 \square Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one Certifying Nurse Practioner. To the best of my knowledge, death oncumed at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 21,2010 63420 Kla 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sid L. Kharal 500 upper chesapeake Dr. Bel Ar , MO 21014 31. Date filed (Month, Day, Year) 2. Registrar's Signature State SEP 23 2010 Registrar

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exember

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 9 Year Physician/ 1:58 P M Thomas D. Bristow 2010 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Salisburg Wicomico HOSPIC If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Days Hours 1 ₹2 M 2 □ F Nov 24, MaryTand 67 **1**1942 Director 216-40-1031 Usual Residence of Decedent r Heath and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d, Inside City Limits 10a, State Director 1 🗌 Yes 2 🗓 No Berlin MD Worcester 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21811 163 Windjammer Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 X Yes 2 ☐
If Yes, Give Black White etc 1 Never Married 2 Married ģ 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify. Specify: white Completed 3 ☐ Widowed 4 🔀 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) gas & electric welder 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Dorothy Lorraine Lembach Charles F. Bristow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 7806 Mayfield Circle Ellicott City, MD 21043 Stacy Al-Mahrouq/daughter homas 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it 1 🗆 Burial 2 🗀 Cremation 3 🗀 Removal from State 9 4 □ Donation 5 ♥ Other (Specify) in state any injury 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Funeral Service Licen. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, & heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final LUNG ARCINDMA Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter or or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Dav Pregnant at time of death 1 Yes 2 G 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at work? 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 \square Pending Natural 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Medical

29a. Certifier

only one

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Sign

WAM

DHMH 17 Rev 7/2009

State Registrar Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Contifying Nystainer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

00058410

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1005AM 20, 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🔀 F Days Months Min Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Pes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 12110 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 Il Hygiene. other than "natural", If Yes Give 1 ☐ Yes 2. No Specify BIOK Completed Specify: 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DONOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ permit. Page 1 and 2 should be of Department of Health and Mental Important: If item 27 is marked 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) armen iontce 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) any injury or ElKridge. 2010 Meadownage Signature of Forieral Service Licensee 22. Name and Address of Facility 20794 10220 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DIEXIA ₽hysician/ weak Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner ekeBROVESCULOr Reledent Villaenmorhog 3 Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical deliosclarosis Sensiale Zed 10 Ges Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant
Unknown 5 Other (specify) Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s PEG Jeeden performe certificate 1 Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital: 2 No Other: ဂ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 — Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3. 29b. Signature and title of certifier 29c. License number uclass had Olive 725410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
O. S. LAWIESS M.D., Swile 310, 18111 Pane Philip DRine, Olvey 140. 20832

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5trace of Maryland 1 October 11 Health and Mental Hygiene

			1 - For State Registrar		" State of Ma	aryland 7 t	•	tificate of			Re	g. No. 2	010	29814
ì	Physici		Decedent's Name	e (First, Middle, La Brenda	st) Ann	Burr	is				Date of Death Month eptembe	Day	Year	3. Time of Death 3:30 D
	/Medi Examir		4a. Fecility Name (/	f not institution, giv	e street and number)			4b. City, Town, o	or Location of D		сресть		ty of Death	3:30 p
7	Funeral Director		1100 St. 5. Social Security 214–54–9	Agnes La	iex 7. Ag	e (In yrs. last bir	thday) Yrs.	Baltimor If Under 1 Year Months Days	If Under 24	Hrs. 8. Min. Sc	Date of Birth (Month, Day, 22	Bali	9. Birthpl	ace (Stete or Foreign
l.	D		Usual Residence of								рг. 22	, 1950		
	Marylar I ehow	tor	MD State	10b. County Baltimo	ore	10c. City, Town							10	od. Inside City Limits 1 ☐ Yes 2 🛣 No
	or 288	Funeral Director	10e. Street and Nur					10f. Zip Code			10	g. Citizen of	What Coun	try?
	s 23e	erail		Agnes La		Towns in 11 C	140.14	21207		0.10		USA		and the discount of the same o
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any fourty or other traumatic event, I'm Micdical Examiliar minal for indifficial and pance.	by	11. Marital Status 1 Never Marri 3 Widowed	ed 2 A Married 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 Th If Yes, Give Year or Dates:		1	Vas Decedent of H Yes, specify Cub ☐ Yes 2 No		i? (Specify uerto Rica	y yes or No- an, etc.)		ice - America ack, White, e ify: Whi	etc.
Maryland 21215-0036	in 72 ho	Completed		15. Decedent's Edify only highest gra	ide completed)		Deced (Give I	ent's Usual Occup kind of work done OO NOT use retire	pation during most of d)	f working	1	6b. Kind of I	Business/Ind	ustry
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and	ould be filed v Mental Hygie Narked other t	Be	17. Father's Name ((First, Middle, Last) Clare		Barbour			_		irst, Middle, M	laiden Suma	,	
aryl	should Ind Men	²	19a. Informant's Na				. Mailin	g Address (Street	Josep and Number o			City or Town	Haber	
	and 2 eelth a m 27 is		Roger S.		(Husband)			St. Agn	es Lane					
nore	Pages 1 nent of H int: If ite			Cremation 3	Removal from State	Baltin	Dispos y, crem IOTE	sition (Name of ratesy or other place Cremato	ry O	Date		Oc. Location		
Baltimore,	permit. P. Departme Important any injury once.		*4 Donation 21. Signature of Fu	5 ☐ Other (Specify neral Service Licen		.] @ Lo	oudo	n Park Name and Addre	9/	/23/1 Loud				aryland
ñ	Depariment important)				3	620 Wilk	ens Ave	e., B	altimo	re, MI		
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C. Box	y the	Physician/M	in the past 12 1 Yes 2 D 9 Unknown	months?	1 Live birth 4 Pregnant at 9 Unknown			Ectopic pregnancy Other (specify)	/					Day Year
cords, r	The law requires that the de tte has been signed by the bage 2 should be detached	þ	Part II. Other signifi	cant conditions of	ontributing to death bu	it not resulting in	the un	derlying cause giv	en in Part I.		23e. Did toba	31		e cause of death?
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VITAI	Physician: r this certific ral director,	o Be	25. Was case referr examiner? 1 Yes 2		Hospital: 1 Inpatier	nt 2 ER/Out		3□ DOA Oth	05		heck only one			
DIVISION OF	Attending Phy death. ctor: After this y the funeral d	\vdash	27. Manner of Death 1 Natural 2 Accident		28a. Date of Injun (Month, Day	y 28b. T		28c. Injur Wor	4 🗆 IANIZII.		5 Resider Describe hove)
N N	To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injubulding, etc	ry - At home, far (Specify)	rm, stre	et, factory, office		28f.	Location (Str. City or Town,	eet and Num State)	ber or Rural	Route Number,
	• Hospi 24 hou • Funer letely fill	ledicai	29a. Certifier (Check only one)	Certifying Ph	ysician: To the best of niner: On the basis of and manner stal	examination and	, death 1/or inve	occurred at the tirestigation, in my o	ne, date and pl pinion, death o	lace, and occurred a	due to the car it the time, da	use(s) and m te and place	anner as sta , and due to	ated. the cause(s)
	To th To th comp	Me.	29b. Signature and	title of certifie	/ Jan	λ		29c. Licens		27	4	d. Date sign		
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			au and addre	DOV W	completed cause of de	ath (Item 23a) (Type. P	ton .	Ane.	F	altin	nove	MD	2010
PT .	Sta Registra		31. Date filed (Monti	h, Day, Year) SEP 2.3.20	32. Registra	r's Signature								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Patricia F. Baca 3:40 P. M Beptember 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4321 Cortez Road **Baltimore** Anne Arundel 5. Social Security Number If Under 1 Year If Linder 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Days Hours 214 48 0313 12726 1947 Mary land Director 62 Usual Residence of Decedent or 28a-f show 10a State 10b. County ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Anne Arundel **Baltimore** Marvland 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 4321 Cortez Road 21225 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black. White, etc. 1 Never Married 2 X Married ģ 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: White Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Media Assistant A.A. Co. Schools 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပ William F. Kenny Jr. Edith Marie Shrewsbury permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marker any injury or other terres or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alberto J. Baca / Husband 4321 Cortez Road Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) Bayview Crematory 09/22/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Gonce Funeral Service, P.A. 22. Name and Address of Facility kion 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. enset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events l-tran Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has b lirector, page 2 s performed Yes 2 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending Accident 1 Yes 2 No Investigation after death Director: / d in by the f Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral I Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) 29h Signature and tive of certifier

DHMH 17 Rev 7/2009

State

Registrar

Name and address of person

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3 2010

eted cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#5perFH,G911,1/20/2011,WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death S Month Year Physician/ 2 Ed word 15 00 240 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 6. Sex If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 5. Social Security Number **213–16–3829** Months 1 Ø M 2 □ F **Director** May 31 1922 Maryland 213-16-3892 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 ☐ No Baltimore Maryland **Baltimore City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 903 Mt. Holly Street 21229 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc. ğ 1 Never Married 2 Married 1 Lyes : 2 No Baltimore, Maryland 21215-0036 1943 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Fort Howard Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Geraldine Lawson Unknown Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 903 Mt. Holly Street Baltimore, Maryland 21229 Barbara Brown 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Owings Mills, Md 09/21/10 4 Donation 5 Other (Specify) Garrison Forest Veterans Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the obease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner bus to (or as a consequence of,: sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 힏 1 🗌 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 🗆 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death James R. Burns Year Physician/ Month :50 FM 0 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** OASTAL VICOM; 00 HOSPICE AT DALISBURY THE CAK 5. Social Security Number 279 – 48 – 7563 Birthplace (State or Foreign Country)
 T-TT-7 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In yrs. last birthday) 1**X** M 2 □ F Days Min. 02/03/ 60 Director WV Usual Residence of Decedent show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Worcester Berlin MD 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 48 Mystic Harbour Blvd. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, e Completed by 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify: 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 212 Elementary/Seconday (0-12) College (1-4 or 5+) Steel Dye Setter 12 Be 18. Mother's Name (First, Middle, Maiden Surname)
Madelyn Smith 17. Father's Name (First, Middle, Last) ပ Raymond James Burns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $48\ \text{Mystic Harbour Blvd., Berlin, MD}$ 21811 Anita Burns / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/21/2010 Woodbine, MD Fi<u>nal</u> JourneyCrem. Maryland Cremation Services PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licensee Dorota Marshall 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ KIDNBY DISPORT STE STACE IV CHRODIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? Month Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2/ No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 1 🗌 Yes Be 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence Hospital 잍 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Mannes of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
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Contr Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 a Huntin BOX 1733 31. Date filed (Month, Day, Year) 2. Registrar's Signature

Registrar

X DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 17 2010 12:07 BAUMGARDNER VALESSA PAULETTE Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🎗 F Months Days Hours Min. Country) 215-72-9360 52 WV **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits death with the Maryland notified at Director MD Frederick Frederick 28a-f 1 🔀 Yes 2 🗌 No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? ms 23a or must be Funeral 6095 Bluestone Circle 21702 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) n "natural", or item ledical Examiner n 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Tech. Account 12 <u>Federal Government</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever 2 Page 1 and 2 should be in ment of Health and Ments Robert Jack Saunders Lillian Ordamdy ^{19a.} Informant's Name/Relationship *(Type, Print)* Eric Baumgardner/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6095 Bluestone Circle, Frederick, MD 21702 item 27 i other tra 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Final Journey Crem. 9/20/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BRENST Ph sician/ METASTATIC CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence oi) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown been Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page perform death? 2 X No 1 Yes 2 No _ Yes Be 25. Was case referred to medica apleted filled in by the funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Ninpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury s after death. 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifier MPD70559

Registrar

DHMH 17 Rev 7/2009

State

West

32. Registrar's Signature

Seventh St. Frederick, Mi)

Seplember 110 2010

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SEP 23 2010

DONALD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Sept. John<u>Henry</u> 5:55pChaney. Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death 529 Beall Avenue Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🙀 M 2 🗆 F Oct. 31, 1931 Tennessee 409-48-4269 Director 78 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 529 Beall Avenue 20850 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White "natural", 3 ★ Widowed 4 □ Divorced Year or Dates. Korea other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 12 should be filed within ? "th and Mental Hygiene. "7 is marked Att marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Auto Mechanic Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Henry Chaney, Sr. Nola Lee Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health Chaney, Son 529 Beall <u>Avenue, Rockville, Maryland</u> Terry Baltimore, tem 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or of 1 🗌 Burial 2 🗶 Cremation 3 🗌 Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) Metro Crematory, Inc. 9/23/2010 21. Signature of Funeral Service License Amanda Heaston 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Lest and D shock, or heart failure. List only one cause on each line Immediate Cause (Final Priysician/ disease or condition resulting in death)) m ϵ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, Isading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of: attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Other (specify) Pregnant at time of death Yes 2 No the g 🗌 Unknown 9 Unknown P.O. been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy certificate 1 Yes 2 🗌 No Yes Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 1 Inpatient 2 I ER/Outpatient 3 I DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: After 12 Natural 5 \square Pending injury Accident Investigation within 24 hours after deati To the Funeral Director: completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) mo DME 20458 50/0 524 Hankeybury 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

Please Type of Print in Black/Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			1 - State Registrar		Cei	rtificate of D	eath	Re	g. No.	0 29820
	Physicia		1. Decedent's Name (First, Middle, La	Louise Pat	ricia Chi	.1ders		2. Date of Death Month September	Day Yea	3. Time of Death 1:10 P. M
	Medic Examir		4a. Facility Name (if not institution, giv 4206 Mariban			4b. City, Town, or	Location of Death	Осрестве	4c. County of De	eath
	Funeral Director		Social Security Number 6.5		yrs. last birthday) 2 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9.1	Birthplace (State or Foreign
		or	Usual Residence of Decedent 10a. State 10b. County		c. City, Town or Lo	ecation		00/13/1		10d. Inside City Limits
	Maryla 28a-f	rect	Maryland N/A	A .	Baltin	nore				1 🏋 Yes 2 □ No
	s 23a or surst be no	Funeral Director	10e. Street and Number 4206 Mariban C	ourt		10f. Zip Code	1225	10	g. Citizen of What U.S.A	
900	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2X No		cify Yes or No- Rican, etc.)	Black, Wi	nerlcan Indian, nite, etc. White
5-0	72 hou "natu edica	plet	15. Decedent's I (Specify only highest g		(Give	dent's Usual Occupa kind of work done de	tion uring most of workir	ng 16	6b. Kind of Busines	ss Industry
212	vithin jiene.		Elementary/Seconday (0-12) 8th	College (1-4 or 5+)		O NOT use retired) nemaker			Own H	lome
Maryland 21215-0036	ild be filed v Mental Hyg narked otheratic event,	To Be	17. Father's Name (First, Middle, Last)	Eldridge Cr	ouch		18. Mother's Name	(First, Middle, Ma.	iden Surname)	
, Mary	nd 2 should salth and Me n 27 is mar l er traumati		19a. Informant's Name/Relationship (Marvin Childers		19b. Mailir 132	ng Address (Street a Midland R	nd Number or Rural oad G1	Route Number, Co en Burni	ity or Town, State, e, Maryla	Zip Code) and 21060
Baltimore,	~ ~ -		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State		osition (Name of matory or other place en Mem. Pa) 00 (0)		oc. Location - City Glen Burn	or Town, State
Balt	permit. Page Department Important: I any injury o	E 78	21. Signatur Fu eral Service Licen	Darida	22	2. Name and Address	of Facility Go:			ce, P.A. ryland 21225
	trysician/		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	death. Do not ente	2	, such as cardiac or	respiratory arrest	,	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	Due to (or as a co	nsequence of):	N3264	deve	male	,	
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_	certificate be executed nding physician and use as the burial-transit	Medical Examiner	that initiated events resulting in death) Last	C. Due to (or as a co	nsequence of):)			·	
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Š Q	death cer ne attendii ed for use	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of o Month	delivery Day Year
s, P.O.	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	ρ	Part II. Other significant conditions of	contributing to death but no	ot resulting in the u	inderlying cause give	en în Part I.			to the cause of death?
örd	w require is been si 2 should	Completed						24a. Was an	24b. Were a	autopsy findings available
ě	Physician: The law this certificate has al director, page 2 ⁹	Com						autopsy performe 1 Yes 2 [d? _ death	o completion of cause of ? 'es 2 No
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<u> </u>	g Physer this eral di	e: To	27. Manner of Death	28a. Date of injury	2 ER/Outpatien 28b. Time of	28c. Injury	4 ☐ Nursing Hon at 2	ne 5 Residence 8d. Describe how	e 6 Other (Spe	ecify)
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DIVISION OF VITAL RECORDS,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2		4 Homicide determined	28e. Place of Injury - building, etc. (St	pecify)		1.	City or Town, S	itate)	Rural Route Number,
	the Hosp nin 24 hou the Funer npleted fil	Medical	(Check 2 ☐ Medical Exam only one) 3 ☐ Certifying Nur	sician: To the best of my liner: On the basis of exami se Practioner: To the best	'nation and/or invest	tigation, in my opinion	, death occurred at t	he time, date and p	lace, and due to the	e cause(s) and manner stated.
	viti Con		29b. Signature and title of certifier	1 Abon	M	29c. License	2729	29d	Date signed (Mor	nth, Day, Year)
			30. Name and address of person who				au Di	. 4 10	a \ 2	Ne 21216
	Stat	е	31. Date fil SEP th 2 3 2010	32. Registrar's S		J. T. T.	20 2 DI	NO B	VIT (VICE	21216

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autopsy performed? 1 Yes 2 Mo 25. Was case referred to medical examiner? 1 Yes 2 Mo 26. Place of Death (Check only one) 27. Manner of Death 1 Natural Solution of Could not be 4 Homicide 28a. Date of injury - At home, farm, street, factory, office 28b. Place of Injury - At home, farm, street, factory, office 29a. Certifier 29a. Certifier 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and Attle of certifier 29c. License number 29d. Date signed (Month, Day, Year)	been sie should k	leted			-2* XI .													
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Rena Dovai 2700 Quarry Lake Dr # 360 Balkmore			30. Name and addre	es of person	who completed of	ause of d	eath (Item	23a) (Type	Print)		2	ak	e Dr	4	36	OF	Salk	more
State Registrar 31. Date filed (Month Day, Year) 2010 32 Registrar's Signature Aparts 217			31. Date filed (Most	EP 23	2010 3			turg.	rank	,)							2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Day 55 PM 2010 Medical give street and number) Name (if not institution, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death sattimore **105** If Under 1 Year 7. Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 D F Months Days Min. Vrs **Director** Usual Residence of Decedent 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Jimits Director 28a-f atti more 1 No Yes 2 □ No ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a oi Examiner must be Funeral within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cubax, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 2 No 21215-0036 1 ☐ Yes 2 ☑ No Specify "natural". 3 Widowed 4 Divorced Completed Specify: the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Bentalou. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Starture of Funeral Service Licenses 22. Name and Address of Facility na 2/10 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause at each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mistal Physician. disease or condition months Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Crosspring Cause (Disease or iinjury that initiated events Due to (or as a consequence of) and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Day Year Pregnant at time of death 2 | No the Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has 24 hours after deatn. **e Funeral Director.** After this certificate holeted filled in by the funeral director, pag ☐ Yes 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) MESOLIA 27. Manner of Death 1 Natural 2 Accident Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) 303 20 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 6701 much 11 AMON mison m

State Registrar 31. Date filed (Month, Day, Year

DHMH 17 Rev 7/2009

32. Fegistrar's Signature

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Moditial Exemples.

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran signed by the a nours after death.

neral Director: Aft
y filled in by the fun

Division of Vital Records, P.O. Box 68760,

4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklin Square Hospita 8. Date of Birth June, Day, 9. Birthplace (State or Foreign Western Wirginia If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Min. Hours 1 🕱 M 2 🗆 F Davs 82 234-38-8715 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1¥ Yes 2 No Baltimore Director MD 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 21205 1110 Steiger Way USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes ŽŽNo If Yes, Give Peacetime Specify: ģ Specifi White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mill Rite Steel Mill 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert \mathbf{E}_{\bullet} Crites Mattie ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Butternut Dr., Baltimore, MD 21220 Patricia A. Kuhn (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/22/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part | Earth | e dishase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, reading to influentiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sua to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 I Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ lung concer otheral fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an 2 No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗹 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Man er of Death 1 V Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 09/18/2010 therew H. WOLDEHIWIT 00063327 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DV, BALTIMURE, MD GIZAW WOLDEHIWOT, MD, 9000 Franklin S9-31. Date filed (Month, Day, Year) registrar's Signature State

830

DHMH 17 Rev 1/2001

Registrar

within 24 hours a To the Funeral D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month SEPTEMB Michael Dorsey 18,2010 ER 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death BALT/MOR

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. ST. AGNES HOSPITAL 7. Age (In yrs. last birthday) B. Date of Birth (Month, Day, Year) 08-13-48 Birthplace (State or Foreign Country) Months 213-54-1539 1**X** M 2 □ F 62 Yrs MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XIXYes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 619 North Grantley Street 21229 USA 14. Race - American Indian, Black, White, etcAfrican 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X If Yes, Give Year or Dates: 2X No 1 X Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: American 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) B. Green Warehouse Warehouseman 9th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chandler Elise Dorsey Joseph 19a. Informant's Name/Relationship (Type. Print) Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy M.E. Harden 929 Kevin Road Baltimore, Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cem. Date 20c. Location - City or Town, State N Burial 2 □ Cremation 3 □ Removal from State 09-24-10 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 23 Part1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SERSI-HOURS Due to (or as a consequence of) ISCHEMIC SMALL BOWEL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Tes 2 No 24a. Was an autopsy pertormed 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

law requires that the death certificate be executed P.0. Records, Division (

Physician

/Medical

Examiner

Director

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Completed

Be

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Examiner

Physician/Medical

Completed by

Medical Certification: To Be

29a. Certifier

(Check only one)

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must hen exercise once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

within 24 hours a

State Registrar

29b. Signature and title of certifer

29c. License number

🗝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0037359 SEPTEMBER, 20, 2010

M. SHEKITKA 900CATON AVE 31. Date filed (Month, Day, Year)

MO

DHMH 17 Rev 1/2001

10-07184 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Joseph Paul d'Entremont, III 010 29825 Certificate of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month September 17, 2010 2224 hrs Mજdical Examiner Joseph Paul d'Entremont III 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Harford Bel Air Upper Chesapeake Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director 1 X M 2 F Yrs Massachusetts 14 010-80-7640 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 X No s 23a or 28a-f show e notified at once, or 28a-f show Maryland Harford Fallston Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2716 Fallsbrooke Manor Drive 21047 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, tem 27 is marked other than "natural", or items traumatic event, the Medical Examiner must be i Armed Forces? White, etc. 1 Never Married 2 Married 1 Yes 2 X No Specify: White If Yes, Give Year 1 Yes 2 No specify: 3 Widowed 4 Divorced remit. Pages I and 2 should be filed within 72 hours after 'epartment of Health and Mental Hygiene.
'portant: If item 27 is marked offer it yor other traumer. ۵ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Public School Student 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Paul d'Entremont Jr. Faith Ann Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph P. d'Entremont Jr./Father 2716 Fallsbrooke Manor Dr., Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Mtn. Christian Cemetery 9/22/10 Joppa, Maryland Department 4 Donation 5 Other Specify. 22. Name and Address of Facility 21. Sign repof Funeral Service License McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear 23a. Part I. Ter the disease, or complication **Physician** Between Onset and failure. List only one cause on each lin /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or es a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit ca UNPENDED AMENDED ned by the attending physician detached for use as the burial -Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by the betached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ۵. 1 Yes 2 No 3 Probably 4 Unknown Completed Records, certificate has been 24a, Was an 24b. Were autopsy findings available prior to completion of cause of performed? ✓ Yes 2 No death? 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital or Attending Physician: funeral director, of Vital Be Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other DOA this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day Year) Sep 17, 2010 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Pedestrian struck by auto To the Hospital or Automore, within 24 hours after death.

To the Funeral Director: A Division Natural 5 Pending 1 Yes 2 ✔ No 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Route 24 at Red Pump Road, Bel Air, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 18, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Daugherty Young Diane Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, Year Sept 15. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** Davs 1 □ M 2 🎛 F Months Hours Min. Indiana Director 138-26-4869 76 Sept Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Medical Examiner must be notified at Funeral Director 1 Yes 2 No Timonium Maryland Baltimore 10f. Zip Code 10g, Citizen of What Country? 0 10e. Street and Number 23a USA 5 Bussing Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important. If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: Be Completed 3 - Widowed 4 X Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Special Education Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Lorts Mae Dorothy Young Cyrus Μ. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2561 Carrollton Rd., Annapolis, MD Deborah Daugherty Richardson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 9/25/10 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Speon) Timonium, Maryland Dulaney Valley Memorial Gardens Bryan W. C1: 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc. Clary W. Padonia Road, Timonium, MD 21093 23a. Part 1. Inter the disease, or compilitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one sause or each line. Approximate Interval Between Onset and Death Immediate C --- (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 X No Month Day Year Pregnant at time of death 1 Yes 2 Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 Hospital Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) After this funeral of 27. Manyfer of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No. within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fun Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MIL ricum 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. legistrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 1

		1	For State Registrar	Otato of many	Cer	tificate of D	eath		Reg. No	In	29827			
	Physicia		1. Decedent's Name (First, Middle, Last))	-			2. Date of Dea	ith	Year	3. Time of Death			
	Medic	al	Iva O. Duvall					Septem			1:53 PM M			
	Examin	er	4a. Facility Name (if not institution, give s Anne Arundel Me		0.71	4b. City, Town, or				y of Death Arun	do1			
	Famous		5. Social Security Number 6. Sex		yrs. last birthday)	Annapo	If Under 24 Hrs.	8. Date of Birt			lace (State or Foreign			
Н	Funeral Director		227-28-9048] M 2 🔀 F	85 Yrs.	Months Days	Hours Min.	June 5	Year) 925	Virg	ginia			
	nd how at	. I	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Loc	cation				10	0d. Inside City Limits			
	arylar a-fsl ified	ecto	MD Anne Aru	nde1	Annapo	lis					1 ☐ Yes 2x☐ No			
	or 28 e not	늅	10e. Step and Number			10f. Zip Code			10g. Citizen of	What Coun	try?			
	with s 23a ust b	Funeral Director	947 Ships Bell Co	urt		21	401		USA					
	death item		11. Waltar Ctatao	12. Was Decedent Ever Armed Forces?	in U.S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ice - America ack, White, e				
980	rs after ral", or Examir	Completed by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 💢 No If Yes, Give Year or Dates.		☐ Yes 2X No				y whi				
2-0	2 hour	plet	15. Decedent's Ed (Specify only highest grad		(Give A	lent's Usual Occupa kind of work done d	ation uring most of work	t of working						
121	thin 7	틵	Elementary/Seconday (0-12)	College (1-4 or 5+)		O NOT use retired)			TIC C		- 4			
0	ed wi Hygie other ent, ti	a l	17. Father's Name (First, Middle, Last)			istrative 	18. Mother's Nam		US Gov Maiden Surnan		nt			
aŭ	be filk ental rked o	잍	Ward Beecher Ower	ns			Lucy Je	nkins						
ary	hould and M s mar umat		19a. Informant's Name/Relationship (Type	pe, Print)		ng Address (Street a				State, Zip C	Code)			
Σ	nd 2 s ealth a n 27 i		John Duvall/son		113	Martha Ro	oad Glen	Burnie,	MD 210	160				
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1	Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place	e)	Date	20c. Location	- City or To	wn, State			
Balti	permit. Departr Importa any inju		21. Signature Funeral Service Licen	firec		Name and Addres tate Anat altimore			. Balti	more	Street			
		П	23a. Part 1 Enter the disease, or compl shock, or heart failure. List only on	lications that caused the					rest,		Approximate Interval Between			
	Pnysician/	8 13	Immediate Cause (Final disease or conviction	Ou/m	onay	em 50	lism				Onset and Death			
	Medical Examiner		resulting in death)	a. D to (or as a co	onsequence f):									
	Examiner	ja l	Sequentially list conditions,	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):										
	ed	m in	if any, leading to immediate cause. Liner or denying Cause (Disease or iinjury	Due to (or as a co	onsequence or,	dence of).								
	ificate be executed g physician and as the burial-transit	Medical Examiner	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):									
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8760	ifficate ng phy as th	Med	IF FEMALE:											
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. Box	re deat / the at ched fo	Physician/	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at tin	ne of death 5 ∟	Other (specify)								
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ital	sician certif recto	Be .	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	o FD/Outrotion	Othe	er:		d 6 🗆 O	ther (Coosifi	A			
1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c.							/ at	ome 5 Residence 128d. Describe l						
The part of the pa						M 1 🗆	? Yes 2 ☐ No							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did 24a. Was provided by the death of the provided by the provid							28f. Location (S City or Tov		ib e r or Rurai	l Route Numb e r,				
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Examin	ician: To the best of my ner: On the basis of exan	nination and/or inves	tigation, in my opinio	on, death occurred a	at the time, date a	and place, and o	due to the ca	use(s) and manner stated.			
	ithin 2 the l	only one) 3 Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tiple of pertifier 29c. License number 29d. Date signed (Month), Day, Ye												
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			30. Name and address of person who co	ompleted cause of deat	h (Item 23a) (Type, I			0						
			30. Name and address of person who charles w. Phel	MUD /3	39 Old)	Olomons I	sience Res.	Hnnap	olis V	41)	c (7°/			
	Sta Registr		SEP 2 3 2010	Service Services	J. Jan	Kel								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Eugene Rucker Dare ам September 2010 8:34 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Potomac 9516 Falls Bridge Lane 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 06/03/1911 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 X M 2 D F 99 Days Hours 535-38-3307 Yrs Director WA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. Count 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Potomac 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 10851 Spring Knoll Drive 20854 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces? 1XX Yes 2 \(\text{No Navy} \) þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 1941-63 Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Navy Captain Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lewis Α. Dare Muriel (unkn) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene Dare Jr., / Son 9516 Falls Bridge Lane, Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Final Journey Crem. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/23/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licencee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CORONARY ARTERY DISEASE Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death sate has been signed by the page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: Son's House 1 XYes မ 4 Nursing Home 5 Residence 6 Other (Spec 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of s after death. 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be filled in by the Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number RES-000 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER LT MC BETHESDA MD 20889-5600 DYE USN 31. Date filed (Month, Day, Year) SEP 2 3 2010 State

HMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Division of Vital Records,

		For State		State of Ma	aryland		artment of F rtificate of L		Mental Hy			
		Registrar 1. Decedent's Nam	ne (First, Middle, Las	t)		001	tilleate of E	- Call	2. Date of De	Reg. No.	2010	3 Time of heath
Physic Med	cian/ dical			Orsa	Jan	e E	verhart				21, 2010	9:46 PM
Exam	niner	4a. Facility Name (i	f not institution, give	street and number)				Location of Death	1	4c.	County of Death	
		7109 De 5. Social Security N	erfield Ro		e (In yrs. las	et hirthday)	Pik	<u>kesville</u> I If Under 24 Hrs.	8. Date of Bir	db.	Baltir	Nore hplace (State or Foreign
Funera Directo		219-34-	4673	M 2 XF	72	Yrs.	Months Days	Hours Min.	May 2	3, Year 9	938 Ma	iryland
nd how	۲ ا	Usual Residence o	10b. County	· ·	10c. City,	Town or Lo	cation					10d. Inside City Limits
faryla Ba-f s tified	50	MD	Balt:	imore			Pikes	sville				1 ☐ Yes 2 🔀 No
the N or 2	قَ ا	10e. Street and Nu	mber				10f. Zip Code			10g. Citi	izen of What Co	untry?
n with is 23a nust b	Funeral Director	7109	Deerfield	Road			21	1208			USA	
death r item iner n	1			12. Was Decedent E Armed Forces?		13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		14. Race - Amer Black, White	
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	P P	1 □ Never Mar 3 😾 Widowed	ried 2 Married 4 Divorced	1 ☐ Yes 2 🔀 If Yes, Give Year or Dates.	No		1 ☐ Yes 2 🙀 No	Specify:				ite
5-0 hours	Completed	(90	15. Decedent's Ed ecify only highest gra	ducation	- 1		dent's Usual Occup		delan m	16b. Ki	ind of Business I	ndustry
21: Thin 72 Than "	1	Elementary/Sec		College (1-4 or 5	+)		kind of work done of O NOT use retired)	-	king			
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", on you or other traumatic event, the Medical Exam	Re C		(First, Middle, Last)				Homemal		/Finsk & Ainlalla		wn Home	
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ore, I		20a. Method of Dis		Removal from State	ce	metery, crei	sition (Name of natory or other plac		Date	20c. Lo	ocation - City or	Town, State
timor t. Page 1 tment of 1 trant: If it				Removal from State			ematory,				Altimore	
Baltimora permit. Page 1 a Department of th Important: If its any injury or of	ouce	21. Signature of Fu	neral Service Licens	George M	lacNak	ob 22	2. Name and Addres	ss of Facility Cr derick Ro			_	MD, Inc. 21228
		23a. Part 1. Enter	the disease, or comp	olications that caused the cause on each line	the death.	. Do not ent						Approximate Interval Between
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Medica Examine	_	resulting in death)	ſ	Due to (or as a								
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/60 cate b physi	edical			d								
certific nding use as	Σ	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, outcome			7				23d. Date of deli	ivery
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al Fian: Tian: Be C	25. Was case refer	/					ace of Death (Chec		2 32 NO) I La les	2 🗀 140	
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n Ol ding F ding F After 1 funerz	Certificate:	27. Manner of Deal	5 Pending	28a. Date of injui (Month, Day		28b. Time of injury	work		28d. Describe	how injury	occurred	
Attendr deat	Į	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not be determined		ry - At hon	ne, farm, str	eet, factory, office	res 2 🗆 NO	28f. Location (Street and	d Number or Run	al Route Number,
DIVISION OT VITAI tal or Attending Physician: rs after death. al Director: Affer this certific ed in by the funeral director.			determined	building, etc					City or To	vn, State)		
DIVISION Of VITAI RECORDS, P.O. BOX 68/ To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one)	2 📖 Medical Exami	ician: To the best of ner: On the basis of ea e Practioner: To the	kamination	and/or inves	tigation, in my opinic	on, death occurred a	at the time, date:	and place,	and due to the c	ause(s) and manner stated.
To the vithing To the complex		29b. Signature and				3-1	29c. License			29d. Dat	e signed (Month	, Day, Year)
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Regis	tate trar		SEP232	010 Jene	un.	B. 19	backer					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year / O Month 09 Day 20 Arthur Larry Faulcon 5:45PM 4c. County of Death N/A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Good Samaritan Hospital Baltimore 9. Birthplace (State or Foreign Country) MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Min 1**X** M 2□ F Months Days Hours 214-56-6636 60 4/1/50 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County MD N/A Baltimore 1 XYes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 936 Abbott Court 21202 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status African 1 Never Married 2 ☐ Married 1 ☐Yeş 2 No Specify: SpecifyAmer. 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Construction Elementary/Secondary (0-12) College (1-4or 5+) Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Selena Jennings James Faulcon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tenika Faulcon/Daughter 936 Abbott Court, Balt., MD 21202 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 9/27/10 Balt., MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. Close F.S, PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the Lease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final , ACUTE RESPIRATORY DISTRESS SYNDRON SEPTIC SHOCK disease or condition resulting in death) Due to (or as a consequence of): 24 ths ASPIRATION PNEUMONIA Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Synoneme, History 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Physician /Medical Examiner

Examine

Physician/Medical

<u></u>

Completed

Be

Certification: To

Medical

29a. Certifier

Physician

Examiner

Funeral

Director

Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or thems 23a or 28a-f show my lighty or other traumatic event, the Medical Evarinar must be notified at once.

12 should be filed within 7 in and Mental Hygiene. 7 Is marked other than "r

Pages 1

Itimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

sician and burial-transit ding physician the use as signed by the atter peen To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

The law requires that the death certificate be executed

Box 68760,

P.O.

of Vital Records,

Division

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MYERODYSPURSIL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DEMIENT autopsy performed? Yes 2™No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1□Yes 2√No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☑ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

State Registrar

TANNIA 31. Date filed (Mo

29b. Signature and title of certifier

H. JUSON MO. egistrar's Signature

and manner stated.

30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Boulevard, Baltimore Maryland 21239

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
 State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN Social Security Number 6. Sex . Age (In yrs. last birthday) 8. Date of Birth **Funeral** BELARUS Months Days Hours Min. 07/28/1923 Director 87 089-16-4758 Usual Residence of Decedent or items 23a or 28a-f show miner must be notified at 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No MD BALTIMORE PHOENIX 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21131 4203 GREEN GLADE ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE "natural", 3 X Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mea College (1-4 or 5+) 5+ Elementary/Seconday (0-12) EDUCATION **TEACHER** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ARONOFF LAIKEN DORA SAMUEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4203 GREEN GLADE ROAD, PHOENIX, MD DONNA ELRICK/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State OHEB SHALOM MEM. PK.: 09/22/2010 REISTERSTOWN, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on experience in the cause of the cause on experience in the cause of the caus Approximate Interval Between Onset and Death Immediate Cause (Final Physician. neumo disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying death certificate be executed the burial-transi Cause (Disease or liniury and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Day Pregnant at time of death 5 1 Yes 2 L 9 Unknown per 9 Unknown the To the Hospital or Attending Physician: The law requires that the P.O. signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes No 3 ☐ Probably 4 ☐ Unknown Records, Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 2 🗌 No certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence ည 1 Tyes this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral Natural work? 1 Yes 2 No iniury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) SEP 2 3 2010 DHMH 17 Rev 7/2009

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State	State of	f Maryland		ertment of H			0.0		
			Registrar 1. Decedent's Name (First, Midd	la Last\		Cer	tificate of D	eath	2. Date of Dea	Reg. No.	10	29832
П	Physicia		Margaret						Month	Day	Year	3. Time of Death
176	Medic Examin		4a. Facility Name (if not institution		ber)		4b. City, Town, or	Location of Death	Septemb	4c. County		0 200
	,			6 Deauville	Court			Pike	esville		Baltin	nore
	Funeral Director		5. Social Security Number 217-24-4202		7. Age (In yrs. last 81	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da Feb 1	h y, Yea <i>r</i>) 5. 192 9	Count	lace (State or Foreign ry) laryland
	nd how at	ř	Usual Residence of Decedent 10a. State 10b. Count	у	10c. City, 7	fown or Loc	cation				11	0d. Inside City Limits
	faryla 3a-f s tified	Director	Maryland	Baltimore			Pi	ikesville				1 🔀 Yes 2 🗌 No
	the N or 20		10e. Street and Number				10f. Zip Code			10g. Citizen of \	What Coun	try?
	n with	Funeral	6 Deauville Court					21208			U.S.A	٨.
36	e filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorce	Armed For	2 X No	lf lf	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 🕱 No	n, Mexican, Puerto	ecify Yes or No- o Rican, etc.)		e - America ck, White, e	
9-0	hours natura lical E	lete	15. Deced	ent's Education		16a. Deced	ent's Usual Occupa	ation	==17,	16b. Kind of B	usiness Inc	lustry
218	iin 72 ie. han "l	d w	(Specify only high Elementary/Seconday (0-12)	hest grade completed) College (1-	4 or 5+)		ind of work done do NOT use retired)		king	Sta	ate Of M	laryland
121	ed within Hygiene. other tha e nt, the l	0	12	1 4			Data F	Processing				
ano	oe filed on the ced other cevent.	To B	17. Father's Name (First, Middle,	eorge Dutton				18. Mother's Nar		Maiden Surname ary A. Kane		
Maryland 21215-0036	should be file h and Mental H 7 is marked o traumatic eve		19a. Informant's Name/Relation			19b. Mailin	q Address (Street a	and Number or Ru	-	-		ode)
	d2shaaltha 127is ertran		Elbert Gross			6	Deauville Cou	urt Baltimore	, Maryland	21208		
Baltimore,	age 1 and 2 should be int of Health and Ment t: If item 27 is marked or other traumatic e		20a. Method of Disposition 1 Burial 2 Crematio	n 3 🗆 Bemoval from		ce of Disponetery, crem	sition (Name of natory or other place	e)	Date	20c. Location -	- City or To	wn, State
ţi	Page 1 tment of tant: If it jury or o		4 Donation 5 Other	(Specify)	Otato	rison Fo	rest Veterans . Name and Addres	s Cemetery	09/28/10	Ow	ings M	ills, Md.
Bal	permit. Page Department of Important: If any injury or once.		21. Signature Fundal Service	Lipensee 5	eral Service Baltimore, M	, P. A.						
Е			shock, or heart failure. List	or complications that c t only one cause on eac	ch line.		r the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a			dionyopa	ilhig				Onset and Death
-	Examiner		resulting in death)	Due to (or as a consequer	nce of):		Q				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Oue to (ог вя в полвасцая	nos ofic						
	uted Id ansit	Examiner	cause, Enter Underlying Cause (Disease or iinjury that initiated events	C								
	ate be executed bhysician and the burial-transit	E E	resulting in death) Last	Due to (or as a consequer	nce of):						
9	ate be executed physician and the burial-transi	edical		d								
687	ertifica ding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregnanc	у				23d Da	te of delive	en/
Box 687	death c e atten ed for u	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of dea		Ectopic pregnancy Other (specify)	у				Day Year
P.O.	at the		9 Unknown Part II. Other significant condit			ina in the u	nderlying cause give	en in Part I.	23e Did to	obacco use cont	ribute to th	e cause of death?
rds, P	equires th een signe rould be c	ted by							1 🗆	Yes 2 □ No	3 🗌 Prob	pably 4 🗌 Unknown
Division of Vital Records,	To the Hospital or Attanding Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending F completed filled in by the funeral director, page 2 should be detached for use as	Completed							24a. Was autoj perfo 1 🔲 Yes	osy ormed?	Were autor prior to cor death? 1 Yes	osy findings available mpletion of cause of
ital	sician certifi rector	Be o	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			_ Othe	ace of Death (Che				
of V	J Phys or this eral di	e: To	27. Manner of Death	28a. Date of	Inpatient 2 EF of injury 28	3b. Time of	28c. Injury	4 □ Nursing F at		dence 6 Other		
nc	inding ath. r: Afte ie fune	icat		tigation	h, Day, Year)	injury	M 1 🗆	? Yes 2□No				
ivisi	l or Atte after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide deter	mined 28e. Place	of Injury - At home ng, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Numb vn, State)	er or Rural	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Medical	(Check 2 <u></u> Medical	ng Physician: To the be Examiner: On the basing Nurse Practioner: 1	is of examination a	nd/or invest	igation, in my opinio	n, death occurred	at the time, date a	and place, and du	e to the cau	use(s) and manner stated.
	To th within To th comp		29b. Signature and title of certifi	er he M.O.		-	29c. License	number 20057-4	65	29d. Date signer	d (Month, L	Day, Year)
			30. Name and address of person N -S - Rajapa	who completed cause	e of death (Item 2:	3a) (Type, P	rint) yenye - S.	-203 /	Baltin	nore, N	10-2	1209
	Stat Registra		31. Date filed (Month, Day, Year) SEP 2 3 20		egistrar's Signatur	bar	V					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	Otato or ivit	•	Certificate of L	Death	R	eg. No. 2	110	20833
	Physicia	n/	1. Decedent's Name (First, Middle, L Brenda E. (.ast) Grandson-Owe	ens	-		2. Date of Death Month 07–08–2	Day	Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, ga			4b. City, Town, o	r Location of Death		4c. County	y of Death	18:43 PM
	xamii		Southern Man	yland Hospi	ital	Clint	on			PG	
	Funeral Director		578-90-5396	. Sex 7. Age 1 ☐ M 2 💢 F	e (In yrs. last birthe 49 Y	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 2–1960	9. Birthp Count Wash	lace (State or Foreign ry) • DC
	aryland a-f show fied at	ector	Usual Residence of Decedent 10a. State 10b. County Charle	os Co	10c. City, Town					10	0d. Inside City Limits 1 □XYes 2 □ No
	vith the M 23a or 28 ist be noti	Funeral Director	10e. Street and Number #9 Walney Ct.	<i>ω</i> .	Waldo	10f. Zip Code 206	602	1	0g. Citizen of	What Count	try?
20	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	If Yes, Give		13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No		ecify Yes or No- Rican, etc.)		ce - America ck, White, e	etc.
20-CI2	in 72 hours e. nan "natura Medical E	Completed	15. Decedent's (Specify only highest Elementary/Seconday (0-12)			Decedent's Usual Occup (Give kind of work done life. DO NOT use retired)	during most of worl	king	16b, Kind of E		lustry
Baitimore, maryland 21215-0036	e filed withintal Hygien ed other the event, the	To Be Co	12th 17. Father's Name (First, Middle, Las		<u> </u>	Unemp Unk		ne (First, Middle, M Evelyn Gi	laiden Surnam	ne)	
Maryic	12 should be fill alth and Mental 27 is marked or traumatic even	-	19a. Informant's Name/Relationship Jeffrey Owens			Mailing Address (Street 972 2nd St.	and Number or Rui	ral Route Number,	City or Town,	State, Zip C	code)
more,	Page 1 and nent of Heal ant: If item ury or other		20a. Method of Disposition 1 Durial 2 Cremation 3 4 Donation 5 Other (Spe	☐ Removal from State	20b. Place of cemetery	Disposition (Name of y, crematory or other pla	ce)	Date	20c. Location	- City or To	
ספונו	permit. Page 1 Department of Important: If it any injury or o		21. Signature of Funeral Service Lice			22. Name and Addre	ess of Facility		Was	shingt	on, DC 2001
رميد.	h sician/ Medical Examiner	if Examiner	23a. Part 1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	a. Due to (or as a		cardial Iv he Coronay	5000				Approximate Interval Between Onset and Death
. DOX 00/00	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	d	2 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify) _	ісу			ate of delive	ery Day Year
.S. T.C.	luires that t en signed by uld be deta	ò	Part II. Other significant conditions	s contributing to death b	nut not resulting in	n the underlying cause g	iven in Part I.	23e. Did tob	_/		e cause of death?
VIIai necorus,	The law rec cate has bee page 2 sho	Completed						24a. Was al autops perfori 1 \square Yes	med?	. Were autop prior to cor death? 1 Yes	osy findings available impletion of cause of 2 No
on or vital	anding Physician: ath. r: After this certifi ne funeral director,	Certificate: To Be	25. Was case referred to medical examiner; 11 Pers 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	28a. Date of inju (Month, Day	ry 28b. Ti	tpatient 3 DOA Oth	4	ome 5 Reside)
DIVISION OF	ital or Atte		3 Suicide 6 Could no 4 Homicide determin	ed 28e. Place of Inju	c. (Specify)	m, street, factory, office		28f. Location (St City or Town	, State)		
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state only one of the cause of the ca						use(s) and manner stated. ated.				
	F ≥ F ö	296. Signature and ittle of certifier 296. License number 296. License number 296. Date signed (M 297. License number 297. License number 298. License number 298. License number 298. License number 298. License number 298. License number 298. License number 298. License number 298. License number 298. License number 298. License number 298. License number 298. License number 298. License number 298. License number 308. Markage 309. Markage 300. Markage						9 7	2010		
	Sta	0	30. Name and address of person with the control of		132 & Signatur	outhern av	une S& S	mtc 310	Washir	y has D	L20032
	Sta Registr		SEP 2 3 2010	Chang	B. Da	Ken					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle 1 am **Physician** 2010 /Medical 4a. Facility Name (If not institution, give str 4b, City, Town, or Location of Death 4c. County of Death et and number **Examiner** Social Security Number Kenap Prince George's 3Ver If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** 6. Sex Age (In yrs. last birthday) Days Months Hours Min 2□ F 87 30. Washington DC Director 312-12-6692 Nov Usual Residence of Decedent ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene.
If item 27 Is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County the Medical Examiner must be notified at 1 ☐Yes 2√ No Director MD Prince George's College Park 10f. Zip Code 10g. Citizen of What Country? 20740 USA 6100 Westchester Park Drive #404 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2∏ No Specify. Specify: white 43-45 3 Widowed 4 Divorced un! 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 sales or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Eleanor Feibleman Mark Moses Gates Sr ္က Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20740 19a. Informant's Name/Relationship (Type. Print) 6100 Westchester Park Drive #404 College Park, Fay Graning/friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4∑ Donation 5 ☐ Other (Spacify) 21. Signature of Emeral Service I cens State Anatomy Board 655 W. Baltimore Street Wade 21201 Baltimore, MD 23a. Part 1. Enter the disease, if complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or teart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Caus (Final disease or conditi n resulting in death) Scheroti Cardis Vascular **Physician** terro Own (/Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): P.O. Box 68760. the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 🗌 Yes 2 □ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2d No 2 **53 N**C 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Accident Injury 5 Pending To the most after death.

To the Funeral Director: Aft 1 □ Yes 2 □ No investigation Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Dercertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type,

Registrar

State

SYEY

31. Date filed (Month, Day,

SASIG

^{Year)} 3 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and num 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Seasons Randallstown Hospice Northwest Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) SC 1 🗆 M 2 🔀 F 79 251-42-2594 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD NA Baltimore Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a USA 21215 3821 W. Rogers Avenue items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. African Armed Forces? ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: American "natural", Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) NA Elementary/Seconday (0-12) Stella Maris Hospide Housekeeper should be filed with h and Mental Hygien 7 is marked other th 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Manning J.A. Hopper Tecola 19a. Informant's Name/Relationship (Type, Print) Daughten 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 Westgate Way Reisterstown, MD 21136 permit. Page 1 and 2 sł Department of Health a Important: If item 27 is any injury or other tra Michelle D. Hopper 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Kremation 3 Removal from State 9-27-2010 Donation 5 Other (Specify) Metro Crematory Baltimore, MD Sign ture of Funeral Service Licensee Wylie Funeral Home P.A. 22. Name and Address of Facility 9200 Liberty Road Randallstown, MD 21133 23a. Pan 1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a conse ence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): for use as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Year Pregnant at time of death s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 certificate has autopsy death? director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 **1**No Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 28d. Describe how injury occurred work?
1 Yes 2 No injury 5 Pending 24 hours after death Funeral Director: A ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and on investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 only one) To the

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

of death (Item 23a) (Type,

		1	State Amend Item 25 p	State of Maryland er me,g908,1	1 / Depa 0/15/ 2	rtment of l	Health Death	and Menta	al Hygi	ene20	0	29836
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	TKRAM				2. Dat	te of Death	Day	Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street Howard County Gener	et and number)		4b. City, Town, c Columbi	or Location .a			4c. County of	of Death	
	Funeral Director		213-03-7324	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days		Min. (Mc	te of Birth onth, Day, 1 -08-	(ear) 1943	9. Birthp Count	lace (State or Foreign ry) India
	aryland a-f show ified at	Director	Usual Residence of Decedent 10a. State 10b. County MD Howard		Town or Loc	cation					11	0d. Inside City Limits 1 ☐ Yes 2 🙀 No
	with the M s 23a or 28 ust be not	Funeral Dir	10e. Street and Number 9528 Chaton Rd.	!		10f. Zip Code 20723	3			10g. Citizen of What Country? Pakistan		
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "and or items and items are a second or items	ē	11. Marital Status 1 Never Married 2XXMarried 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★★ lo If Yes, Give Year or Dates.	l1	Vas Decedent of I Yes, specify Cub ☐ Yes 2XXV	an, Mexica	n, Puerto Rican,		Black	- America K, White, 6	etc.
Baltimore, Maryland 21215-0036	ithin 72 hou iene. r than "nati the Medica	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Seconday (0-12)		(Give I	lent's Usual Occu kind of work done O NOT use retired Naker	st of working	- 0	16b. Kind of Bu Housewi		lustry	
/land	d be filed w Mental Hygi arked othe Itic event,	To Be	17. Father's Name (First, Middle, Last) Malik M. Naseeb Kha	n				ner's Name <i>(First,</i> f ia Begu l		aiden Surname,)	
, Man	nd 2 should lealth and N m 27 is ma		19a. Informant's Name/Relationship (Type, Mohammad Sajjad / S		er or Rural Route	MD 20	723					
timore	t. Page 1 a tment of H rtant: If ite ijury or oth	20a. Method of Disposition 1 Burial 2 Cremation 3 Rea 4 Donation 5 Other (Specify)	metery, cren Nation	sition (Name of natory or other planal Memor	rial (10	Laurel,	•	wn, State		
Ba	permi Depar Impo any ir		21. Signature of Funeral Service Licensee Maler 52 23a. Part 1. Enter the disease, or complica	MOLY52	128	Name and Addr endon-Bas 318 F. Bases the mode of dv	altimo	ore St.,	_Balt	imore,	MD 2	1224 Approximate
	Pnysician/ 4 Medical	8 4	shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	ause on each line. SEPTI Due to (or as a conseque	c SH	ock						Interval Between Onset and Death
كيمين	Examiner	Jer	Sequentially list conditions, b.	b. Due to for as a consequence of:								
	aath certificate be executed attending physician and for use as the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	METHOLUM Due to (or as a conseque	PESIS ence of):	TANT ST	APHY	LOCUCUC	AURE	Y MEDICAL EXAM	MINER	
3760	fficate be g physic as the bi	Medical	d.					CENTIFICATION A	PROVED			
Division of Vital Records, P.O. Box 687	e death certi the attendin hed for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of do g ☐ Unknown	Ideath 3	Ectopic pregnal Other (specify)	ncy			23d. Dat	e of deliventh	ery Day Year
s, P.O.	uires that the dea n signed by the a id be detached fi		Part II. Other significant conditions control Clostfidian dif	buting to death but not resu しんしと	ulting in the u	ınderlying cause ç	given in Par	t I. 23	3e. Did tob			ne cause of death?
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ta	ician: T	Be	25. Was case referred to medical examiner?	spital: 4		100	hor:	ath (Check only o	ne)			
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	To t with To t		29b. Signature and title of certifier	MCO		29c. Licen	se number	662		9d. Date signed	2//	2010
	•		30. Name and address of person who com	4.2		Print) -Ourty	Horin	ital	57 Cdu	55 CEX	De G	N. 1044
I	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 3 2010	62. Registrar's Signat		Ke	· •			· · · · · · · · · · · · · · · · · · ·		

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		1- For State Certificate of Death Registrar		g. No.	
Physicia edical Exami		1. Decedent's Name (First, Middle, Last) Joyce Lillene Jackson	Date of Death Month September	Day Year	3. Time of Death 2127 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Decoration of Decora	ath	4c. County of Death Baltimore Cou	nty
Funeral Director		5 19 · 62 · 248 1 M 2XF	Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Bird Foreig Cor	hplace (State or n Waylington untry) DC
te Maryland or 28a-f show any fied at once.	Director	10e. Street and Number 10f. Zip Code	or Mill	g. Citizen of What Cour	10d. Inside City Limits 1 Yes 2 No
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygene. fant: If iten 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	ģ	3 Widowed 4 Divorced It Yes, Give Year or Dates: 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use results of the property of the	retired)	Specify: SI	
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ore, MD 21215-003 set and 2 should be filed within set and 2 should be filed within and Mental Hygiene. If item 27 is marked other the traumatic event, the Med	o Be		Wilkerson Rural Route Number		Zip Code)
and 2 sho lealth and tem 27 is traumati		Jacqueline Code/Family Friend 3613 Dennlyn Rca 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		20c. Location - City or	
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	y)	21. Signature of Fyrreral Service Licensee 22. Name and Address of Facility V 8728 Liberty Roa	d Randa	(Lotown MD	21133
Physician Medical Examiner	9 6	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line. Immediate Cause (Final disease a Atherosclerotic Cardiovascular Disease	c or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	울	Sectopic pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Yes 2 No 9 Unknown 2 Unknown 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 9 Unknown 9 Un	gnancy	23d. Date of delivery Month D	ay Year
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Division of To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After tompletely filled in by the funeral	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d at the time, date a	nd place, and due to the	e cause(s)
	Σ	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mor September 13, 2	
		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			

State

Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ :57PM Medical e (if not institution, give street and number) 4b. City, Town or Location of Death **Examiner** 4c. County of Death owson If Under 1 Year If Under 24 Hrs. 9. Birthplace (State Age (In vrs. last birthday) 8. Date of Birth **Funeral** or Foreign 1 M 2 (Month, Day, Year) 3 Months Country) Yrs **Director** or 28a-f show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Medical Examiner must be notified at Director 3altimore 1 Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 23a 21218 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ ğ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify Specify: "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State Funeral Service 21. Signature 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ SMa Dan disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) if any, reading to minimodate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Vear 5 Other (specify) 9 Unknown detached 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. within 24 hours after death.

To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? δ Records, 3 Probably 4 Unknown 1 Tes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) Division of Vital examiner? 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3. Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 32. Registrar's State Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

M



2434 W. BELVEDERE AVENUE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE CENTAGE CTA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 19 Physician/ , 201d 4:22p M September Virginia Ann Jordan Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore 4b. City. Town, or Location of Death **Examiner** Towson Greater Baltimore Medical Cente If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral oct. 22, 1933 1 🗆 M 2 🛛 F Months Pennsylvania Director 76 206-26-1684 Usual Residence of Decedent 28a-f shov 10a, State 10b, County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 21093 USA 218 Purlington Road or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Armed Force Black. White, etc. þ 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates. 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exarone. Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eleanor (unk) Hopkins Joseph Simon Dargis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218 Purlington Road, Timonium, MD 21093 Thomas Jordan / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bel Air Memorial Gdn. 9-23-10 Bel Air, Maryland 21. Synathy of Furnal Service Joseph McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon. his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complication Approximate Interval Between Onset and Death shock, or heart failure. List only one cause -suptreshock Immediate Cause (Final Physician/ wram disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** YM MML sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) death certificate be executed the burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 as 1 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No į Month Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown P.0 The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe Cacheckia Records, 1 🗆 Yes 2 No 3 Probably 4 Unknown page 2 should cullocuston 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred : After t 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Cartificial Nurse partitions of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed within 2. 3 Certifying Nurse Practionen To the best of my thousedge, death unsumed at the time, date and plane, and due to the causely) and manner as state the 29b. Signature and title of centifie 29c. License number 25711 20 110 CHARLES ST. TOWSON, MD 2120

State Registrar 31. Date filed (Month, Day, Year)

	State Registrar 1. Decedent's Nar	me (First, Middle, L	.ast)		Cert	tificate of	Death	2. Date of De				98L ime of Deat
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niner	-		ive street and numb	•			or Location of Deatl	h	4c. C	County of D	eath	
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힏	MD			1	Balti							Yes 2
Direc	10e. Street and N	umber Ann Stre	et #620			10f. Zip Code	1231		10g. Citize	en of What	Country?	
era	11. Marital Status		12. Was Decede	nt Ever in U.S.	13. W	as Decedent of	Hispanic Origin? (S	Specify Yes or No	0- 14	4. Race - A	merican Inc	dian.
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5	Tage J	ensen					Elly	Ostenfe	eldt			
		Name/Relationship	(Type. Print)	1	19b. Mailing	Address (Stree	et and Number or Ri	ural Route Numb	ber, City or	Town, Stat	e, Zip Code)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 29842 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2358 Wendell Lee Johnson Sr Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner (emor)a astor 10160 5. Social Security Number 1 Year If Under 24 Hrs. If Under 8. Date of Birth
Jan 4, 1927 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours Min 1 🕅 M 2 🗆 F ennsylvania 83 Director 193-20-9570 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director event, the Medical Examiner must be notified 1 Yes 2 No MD Caroline Federalsburg 10e. Street and Number ò 10f, Zip Code 10g. Citizen of What Country? Funeral items 23a 141 Brooklyn Avenue PO Box 231 21632 IISA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after comportment for Health and Mental Hygene.

Theopartment is marked other than "natural", or marked other than "natural", or any injury or other traumatic event, the Medical Examin ð 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 反 No Specify. Completed Specify. 3 Widowed 4 Divorced black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Baltimore, Maryland 2121 College (1-4 or 5+) musician entertainment Be unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendell Johnson Jr/son 6523 1/4 Crenshaw Blvd Los Angeles, CA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 □ Donation 5 ☑ Other (Specify) in state Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Arter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Physician/ arcinomo Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) s been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Thknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t performed After this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? in by the funeral director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Tes 1 Dempatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Suicide 2 No Investigation within 24 hours after deatl To the Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined completed filled Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 5 00 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Eastern,MD21601

Dennis Michael DeShields Memorial Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 🗸 1. Decadent's Name (First, Middle, Last) 2. Date of Death Physician/ 402 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4c. County of Death land 0 N/A 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours So. Carolina Director Jul 10, 1927 213-32-9039 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗗 Yes 2 🗆 No N/A **Baltimore** Maryland 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21230 U.S.A. 764 Carroll Street items death . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. P Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: Black "natural", 3 ☐ Widowed 4 ☐ pivorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Classie Dingle Wilson Dinale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 Archer Street Baltimore, Maryland 21230 Betty Jones 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Keurial 2 Cremation 3 Removal from State injury or 09/22/10 Lansdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 21. Signature of Europeal Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md. 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) as the burialphysician Physician/Medical Records, P.O. Box 68760 pulpu IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 \(\hat{\text{\text}}\) Ectopic pregnancy atter in the past 12 months? jo Month Day Year Pregnant at time of death Other (specify) 2 No 9 Unknown the hed Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has page 2 autopsy 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No မ ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending To the Hospital or Attendir within 24 hours after death.

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of

31. Date filed (Month, Day, Year)
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completed cause of death (Item 23a) (Type

32. Registrar's Sign

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29b. Signature and title of certifier O.C.M.E. September 20, 2010 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) September 20, 2010	the H nin 24 the Fu	ical	(Check only 1 Certifying Physici										
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Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 2. Registrar's Signature		}	30. Name and address of person who	completed cause of o	leath (Item	23a)							
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral		pecify Cuban, Mexican, Puerto I		White, etc.	
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2 hours			sual Occupation (Give kind of w working life. DO NOT use retire		16b. Kind of Business/In	dustry
036 ithin 7: ne. r than	Completed	12 Mainter	nance		Home Bui	lder
15-0 filed w Hygie d other		17. Father's Name (First, Middle, Last)	18.Mother's Name			-
212	To Be	Jack Stoner Kauffman Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addr	Patricia ress (Street and Number or R	a Lee Ti ural Route Numb	rimble per, City or Town, State,	Zip Code)
MD 12 sho th and 127 is umatic	_		rans Drive, Ab			
or tra		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State crematory or other pla	ace)	Date	20c. Location - City or T	
timent ritant:		4 Donation 5 Other Specify: 21. Şigngare of Funeral Service Licensee 22. Name:		20/10	Bel Air,	
Balt permit. Departi Importi			Cokesbury Road		Funeral Home Edon, Marvla	•
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mo failure. List only one cause on each line.				Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Fentanyl intoxicati	Lon			Death
+		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
	iner	if any, leading to immediate Due to (or as a consequence of):				
at. d	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
, P.O. Box 68760, res that the death certificate be executed signed by the attending physician and be detached for use as the burial - transit	a	d. AMENDED AMENDED 27 282-f por ME	000 10/07/10			
60, ate be o	Wedi	AMENDED 23a,27,28a-f,per ME IF FEMALE: 23c. If yes, outcome of pregnancy	g908 10/2//10	TT	23d. Date of delivery	
687 certific rding p	ian/	past 12 months?		псу	Month Da	ay Year
Box death he atter	Physician/	1 Yes 2 No 9 Unknown 9 Unknown Other (S	Specify)			
hat the detache	by P	Part II. Other significant conditions contributing to death but not resulting in the undert	ying cause given in Part I.		2 No 3 Proba	
IS, P.C quires that en signed	ted			24a. Was a		opsy findings available
Cords: law require has been	Completed	-		autops	ned? death?	empletion of cause of
tal Rection: The certificate ector, page		25. Was case referred to medical	26.Place of Death (Check of	1 ✓ Yes 2 inly one)	No 1 V Yes	2 No
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n of ding Pt After funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?		ow injury occurred abused fer	itanvl
Atten	icati	Perioding Fd 9/14/10 Fd 1220 h	irs —			
Div Dital or ours after	Certification	Suicide 6 Could not be determined (Specify) hospital		Med Ctr	treet and Number of Rur ate) Upper Che Ru Bel A	ir, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	t the time, date and place, and n my opinion, death occurred at	due to the cause the time, date a	e(s) and manner as state and place, and due to the	d. cause(s)
F 3 F 8	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	
B) 0		MM C JMA	O.C.M.E.		September 15, 20	
Bloom		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Per	nn Street, Baltimore, MD	21201		
Sta		31. Date filed (Month, Day, Year)			OGME	
Registi		ORIGINAL		001		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2010 September Doris Katherine Kohl 10:15 A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore Social Security Number If Under 1 Year 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Sountry) Maryland 1 □ M 2 🔀 F Months Days Hours Month, Day, Y July 23 Year) 213-40-1997 70 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 ื No Maryland Harford Abinadon 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 3605 Washington Avenue 21009 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital <u>Dietarv Aide</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene Stanford Miller Florence Evaline Rader 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Kohl / Son 3605 Washington Ave., Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) George Epis. Cem. 9-20-10 Perryman, Maryland 22 Name and Address of Facility
McComas Funeral Home, P.A. re 1317 Cokesbury Road, Abingdon, Approximate Interval Between End Onset and Death Ken PCRTE Due to (or as a conse mence of):

Physician/ Medical Examiner

nding physician and use as the burial-tran

use

been signed by the sahould be detached

page 2 s has

funeral director,

this certificate

After

within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu

The law requires that the death certificate be executed

Records, P.O. Box 68760

Division of Vital Hospital or Attending Physician: Physician/

Medical

10a. State

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or 28a-f shov

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and Mental Hygiene.

traumatic

permit. Page 1 and 2 should be Department of Health and Menr Important: If item 27 is marke any injury or other traumatic

death v

hours after

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

Examiner Physician/Medical Š Completed Be

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Certificate:

Medical

only one)

29b. Signature and title of certifier

N 31. Date filed (Month, Day, Year)

V. Kanp

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of the heral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 4 | Pregnam a 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hesses Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

12125808

29d. Date signed (Month, Day, Year)

-2010

29c. License number

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1— State Amend ITems 23aPt1,25 per me, g907.09/23/2010dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Edward Earl LaBoo Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death of ethmore (Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F 10-17-7ay, Year) 47 218-44-3253 Maryland 62 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a Guard Laion 1 🔀 Yes 2 🗌 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2906 Woodland Ave. 21215 U.S. items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give "natural", or item edical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 10 · þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🖾 No Specify. 3 Widowed 4 X Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) entary/Seconday (0-12) College (1-4 or 5+) 12th Grade Steel Worker Steel Corporation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Monson LaBoo Ella Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3700 Brenbrook Dr/Randallstown, MD 21133 Karen LaBoo / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State King Park Memorial 9-17-2010 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Murray & Tellington Funeral Signature of Funeral Service Licenses > MU1182 Home/4804 Georgia Ave, NW/Wash., DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.
Acute Renal Failure Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Cardiac Arrhythmia Examiner Sequentially list conditions, Examine if any, leaving to immediate cause. Enter Underlying CERTIFICATION APPROVED BY MEDICAL EXAMINER Cause (Disease or iinjury that initiated events Due to (or as a consequence of): and for use as the burial-tran resulting in death) Last Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Year Day 1 Yes 2 No Unknown be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Tes completed filled in by the funeral director, page 2 should has been 24b. Were autopsy findings available prior to completion of cause of ow autopsy performed' death? 1 ☐ Yes 2 ☑ No certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 卢 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) V Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the only one) 29b. Signature and title of certifie 29c. License numbe

State Registrar ted cause of death (Item 23a) (Type, Print)

Registrar's Signatu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician/ Larkins Scotem ESTNer Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death 120kins BAYVICW 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗹 F Months Days Hours **Director** shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10a. State 10b. County or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 10e. Street and Number 10g. Citizen of What Country? Funeral 21228 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates 3 ₩Widowed 4 □ Divorced Specify: Black Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Midelle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a/Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 001 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ott Date 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) -2010 21. Signature of Funeral Service License the Funeral 8728 MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition a. . Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Other (specify) Month 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed' 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending (Month, Day, Year) 1 Natural

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit **Division of Vital**

al Certifi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	ctory, office 28	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,)
Medica	(Check 2 Medical Examir	cian: To the best of my knowledge, death occur her: On the basis of examination and/or investigation or Practioner: To the best of my knowledge, death	n, in my opinion, death occurred at the	the time, date and place,	, and due to the cause(s) and manner stated.
	29b. Signature and title of certifier		29c. License number	29d. Dat	te signed (Month, Day, Year)

1 Yes

RES- OUG

AVENUE

2 No

Baltimore,

9

1 Yes 2 No

Services

Approximate Interval Between

Onset and Death

Day

JEDREMBER 19, 2010

MO

21224

day

Year

State Registrar 2. Registrar's Signature

4940

Crus

CVUZ 2 3 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Oc,e,& f. per FH G907 9/23/10 TT
State of Maryland / Department of Health and Mental Hygiene Amend 10c,e,& for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Mary Ann Luebbe Sept. 1:15 A M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death Examiner Timonium Baltimore Stella Maris 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 □ M 2 □ F Months Days Hours Min. Country) England Yrs **Director** 214-58-8181 Feb. Ĩ929 Usual Residence of Decedent 10a. State 10b. County or 28a-f shorn with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No -Towson Timonium MD Baltimore ō 10e. Street and Number 2300 Dulaney Valley Road 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 21093 325 Joppa Rd. 21286 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes X No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Specify: white Completed 3 Widowed 4 X Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 n/a Homemaker Own Home other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Mary Ann Kearns Thomas Cassidy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Susan Marie Luebbe/daughter 15404 Tanyard Rd., Sparks, MD 21152 Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 🗀 Cremation 3 🗀 Removal from State 9/23/10 Glen Burnie, MD Atlantic Crematory 4 ☐ Denation 5 ☐ Other (Specify) Fyrnge Service L Bryan W. C. 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or he rt failure. List only one cause on each line. Approximate Immediate Ca ... e (Final disease or condition resulting in death) END Onset and Death STAGE Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of, attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown g Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes the Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🛛 No Other ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work?
1 Yes after death. 2 🔲 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and t 29d. Date signed (Month. Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP2300 DULANEY VALLEY ROAD MD 21093 TIMONIUM, 31. Date filed (Mont) trar's Signature State Registrar

DHMH 17 Rev 7/2009

21

SEPTEMBER

LUEBBE

MARY

				partment of Health and Mental I partificate of Death	Hygiene Reg. 2 010 29850						
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) MARGARET	LEE 2. Date of Month SCP	of Death Day Year One of Death						
	Funeral	er	4a. Facility Name (If not institution, give street and number) Future Care Irvington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 □ M 2 □ F 90 Yrs.	Baltimore J. If Under 1 Year If Under 24 Hrs. 8. Date of							
	Director wows	_	404-32-/9/5 Usual Residence of Decedent 10a. State	ocation	10d. Inside City Limits						
	with the Ma a or 28a-f	Director	MD Balti 10e. Street and Number 27 S. Athol Avenue	10f. Zip Code 21229	10g. Citizen of What Country?						
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "neturet", or Items 23e or 28e-f show any figury or other traumatic event, I're Madical Extrail at Least be mailfied at ance.	by Funeral		Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc) 1 Yes 2 No. Specify:	USA or No- 14. Race - American Indian, Black, White, etc. Specify: white						
1215-00	within 72 hou lene. than "neture re Modical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) ecretary	16b. Kind of Business/Industry federal govt						
yland 2	ould be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last)	unk 18. Mother's Name (First, Mi	iddle, Maiden Sumame) unk						
Baltimore, Maryland 21215-0036	1 and 2 sho Heelth and tem 27 is my		Antoinette Ellis/caregiver 323 20a Method of Disposition 20b. Place of Disp	ling Address (Street and Number or Rural Route N N. Grantley Street Bal cosition (Name of Date							
	armit. Pages spartment of sportant: If is to injury or of		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) in State 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location • City or Town, State 20c. Location • City or Town, State 20c. Location • City or Town, State 20c. Location • City or Town, State 20c. Location • City or Town, State 20c. Location • City or Town, State 20c. Location • City or Town, State 20c. Location • City or Town, State 20c. Location • City or Town, State 20c. Location • City or Town, State 20c. Location • City or Town, State 20c. Location • City or Town, State 20c. Location • City or Town, State 20c. Location • City or Town, State 20c. Location • City or Town, State 20c. Location • City or Town, State 20c. Location • City or Town, State 20c. Location • City or Town, State 20c. Location • City or Town, State								
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	To the Hospitei or within 24 hours afte To the Funerei Diracompletely filled in In	Medical	29a. Certifier (Check only one) 1								
)	⊢ s ⊨ ō		30. Name and address of person who completed cause of death (Item 23a) (Typ	D 57543	9-17-10						
	Sta Registi		31. Date filed (Month, Pay Year) SEP 23 2010 Server S. January S.	NOW. BALTIMORE G. B	ALTIMORE, MD 2,223						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9, 11, 15, 17, 18, 19, 26, Per ANA BD G913 3/11/2011 III. State of Maryland Department of Health and Memail Hygiene 29851 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 09 Year 10 Physician/ DORIS I_OW M 6.30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death GOOD SAMPRETON HOSPITA. BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Min. 1 🗆 M 2 🔯 F Maryland **Director** 213-60-0144 Mar Usual Residence of Decedent show 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4413 Falls Bridge Drive #H 21211 USA -unk 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: black Completed 3 Widowed 4 Noivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk unk 16h. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) is marked other injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ည Augustus LOw Celeste Dennis 19**485**lin**Gleens MaranCVrrt;Glen/FBorvnrbe,AID**r **72/1064**, Zip Code) 193 hfarranti Namo (Ref Soisbit (Eve., Print) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau 5601 Loch Raven Blvd Baltimore. Good Samaritan Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state Sicense agle, konald 28 Mare and Address of Figure Board 655 W. Baltimore Street Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death WITH DISSEMINATED INTRAVASCUUM CORGULATO Physician/ disease or condition resulting in death) sernc shock 24 Hours Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Month Dav Year Pregnant at time of death been signed by the should be detached 1 ☐ Yes 2 Marg 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION, END. STAGE RENAL BISEASE Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CORONARY ARTERY DISEASE 24a. Was an cate has autopsy performed? Yes 2 certificate 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes e Hospital or Attending Pl n 24 hours after death. e Funeral Director; After the bleted filled in by the funera Certificate: 28d. Describe how injury occurred injury 1- Natural 5 Pending 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined To the Hospital or within 24 hours aff To the Funeral Di completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) TANNIA H. JUSON, MD RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCIL RAVEN BOMENARD, BATHWARE MID TANNIA H. JOSON, MD

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene														
			For State	State of Ma	arylan	-	artment of I <i>rtificate of I</i>		Mental Hy	ental Hygiene Reg. No.2010 29852				
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	hysicia Medic	cal	FAY	LA				Month SEP		o zear				
	Examin	er	4a. Facility Name (if not institution HOWARD COUNTY			4b. City, Town, o	r Location of Death	1	4c.	ath)				
	uneral rector	Г	5. Social Security Number 078–28–6127	6. Sex 7. Age	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bit 09/29	rth	9. Birthplace (State or Foreign				
			Usual Residence of Decedent		72				1 09/29	/193	/	NY		
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nor age 1 a	Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show myn riuny or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 XBurial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) NEW MONTEFIORE CEM. 20c. Location - City of Cemetery, crematory or other place) NEW MONTEFIORE CEM.											
baltimor permit. Page 1 Department of			4 Donation 5 Other (Specify) NEW MONTEFIORE CEM. 109/22/2010 PINELAWN, NY 21 Ignatore of uneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC.											
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Dh.o	sician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition								Approximate Interval Between Onset and Death			
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Physic	this or	욘	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		ER/Outpatier 28b. Time of	oth 3 DOA Oth	4 LJ Nursing H	1	esidence 6 Other (Specify)				
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To the Hospital or Attending within 24 hours after death.	e Funera	Medical	(Check 2 \(\sum \) Medical E	g Physician: To the best of a Examiner: On the basis of ex g Nurse Practioner: To the l	xamination	and/or invest	tigation, in my opinic	on, death occurred a	at the time, date a	and place,	and due to the	e cause(s) and manner stated.		
To th	To the		29b. Signature and title of certifier	··			29c. License	e number		29d. Dat	e signed (Mor	oth, Day, Year)		
			30. Name and address of person	who completed cause of de	_	23a) (Tvna 📮		43662		26	> Z0, 2	2010		
			William Bo	yce HOWAR	-									
R	Stat legistra		31. Date filed (Month, Day, Year) SEP 2 3 20	3 Registra	r's Signat	ure Air	R.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 25 per me,g907,09/23/2010dhb Certificate of Death Reg. No. Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9:52 PM Victoria Ruth McKimens eptember Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical CEnter Air If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min. Maryland 06/19/1947 **Director** 220-52-5099 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits MD Harford Forest Hill 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 21050 1611 Samantha Drive U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 X Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Maryland 2121 is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Credit Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ano ...
If Health ano ...
If item 27 is markeu ...
''er traumatic ev and Mental 2 Lydia Amelia Hannewald Orville Edward Lassahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46 Stoneway Place - Baltimore, Maryland Barbara Kennedy (sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 09/08/2010 | Baltimore, Maryland Parkwood Cemetery 21. Sign turn of Funeral Service Libenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease: Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ater the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to minute cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Physician/Medical Exami signed by the attending physician and I be detached for use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate Coag Vital 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death Check only one, examiner? 1 Yes 2 No Other 은 ER/Outpatient 3 DOA 1 Inpatient 2 🗆 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 No Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only on Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state. 29b. Signature and title 20053568 500 upper Chesapeak o Drive Bel Air Haryland 21014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

O.

McKimens

DSON

			Please - For State Registrar	State of Maryland /	Depa		Health and	Mental Hyg	•			
	Physicia Medic	al	1. Decedent's Name (First, Middle, Last James K. Middlet	on				2. Date of Dear Month Septem	ath 3. Time of Death ber 12, 2010 4:10 AM M			
4	Examin	er	4a. Facility Name (if not institution, give s Stella Maris	street and number)		4b. City, Town, o Timoni	r Location of Deatl .um	n		4c. County of Death Baltimore		
	Funeral Director		5. Social Security Number 214-16-5090 Usual Residence of Decedent	X M 2 \square F 7. Age (In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 10	, 1917 P	Birthplace (State or Foreign Country) ennsylvania		
	Maryland 28a-f show notified at	Funeral Director	10a. State 10b. County MD Baltimor	10c. City, Tov		2	-			10d. Inside City Limits 1 Yes 2 No		
	with the	eral	10e. Street and Number 2107 Arlonne Driv	re		10f. Zip Code	21228		10g. Citizen of What US			
9800	rs after death ural", or items LExaminer mu	þ	11. Marital Status 1 Never Married 2 XMarried 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 14 Yes 2 No If Yes, Give Year or Dates.	l If	/as Decedent of H Yes, specify Cuba ☐ Yes 2 🌠 No	ispanic Origin? (S _i nn, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ar Black, WI Specify: W			
Maryland 21215-0036	within 72 hou giene. ier than "natu is, the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12) 12	ucation de completed) College (1-4 or 5+) 4	ation during most of wor ion	king	16b. Kind of Busines	Kind of Business Industry unk				
and	be filed antal Hy ced oth c event	To Be	17. Father's Name (<i>First, Middle, Last</i>) James Kearney Midd	ileton Sr				me (First, Middle, M	Maiden Surname) ine Schwie	icar		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type Claire Cohagen/da	pe, Print) 19			and Number or Ru		City or Town, State,	Zip Code)		
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 🏋 Donation & ☐ Other (Specify,	Removal from State cemete		ition (Name of atory or other plac	ee)	Date	20c. Location - City	or Town, State		
Balti	permit. Departr Imports any inji		21. Signatur of Funeral Serve Licenses, Divertor State Anatomy Board 655 W. Baltimore Baltimore, MD 21201									
	Medical Examiner prize p	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Sause (Final disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
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	he Hosp in 24 hou he Funer	Medic	(Check 2 Medical Examin	cian: To the best of my knowledge, er: On the basis of examination and/ e Practioner: To the best of my know	or investig	gation, in my opinio	n, death occurred	at the time, date an	d place, and due to th	e cause(s) and manner stated.		
	To t		29b. Signature and title of certifier	2 CANP	29d. Date signed (Mgnth, Day, Year)							
			30. Name and agrees of person who co	mpleted cause of death (Item 23a) NP 2300 DULANEY		,	ТТМОМТТ	W WD 01	7 7			
	Stat Registra	-	SEP 2 3 2010	32. Registrar's Signature			TIMONIU	M, MD 21	193			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9 Physician/ 00 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 607 Penn. Ave-Apt. 308 Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 47 yrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗗 F Months Director 219-74-0609 Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits N/ABaltimore MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21201 USA 607 Penn. Ave - Apt. 308 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. African Amer. 1 ☐ Yes 2 ☐ No If Yes, Give Completed by 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Maint. Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Daisy Smith Eddie Miller 19a. Informant's Name/Relationship*(Type, Print)*Daisy Miller/Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 Penn. Ave -Apt. 308, Balt., MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 9/25710 Trinity Cem. ¥☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Balt.,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Hari P. Close F.S., PA 5126 Belair Rd, Balt., MD 21206-5105 8 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) 2 🗖 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month. State Registrar

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Jerrell Murray, J	11.	State of Maryland / Department of F			2010	2985
Physici Medical Exami		1. 1. Decedent's Name (First, Middle,Last)	Jr	2. Date of De		3. Time of Death 0608 hrs
		4a. Facility Name (if not institution, give street and number)	City, Town, or Location of De Baltimore		4c. County of Death Baltimore Cou	
Funeral Director			If Under 1 Year If Under 24I Months Days Hours M	Hrs. 8. Date of B	irth(MM/DD/YYYY) 9. Biri Foreig	thplace (State or
		Usual Residence of Decedent	29	Aug		untry) // D
d how any	_	10a. State 10b. County 10c. City, Town or Location	20.00			10d. Inside City Limits 1 XYes 2 No
Marylan 28a-fs	Director	10e. Street and Number	MOCE Of. Zip Code	T I	10g. Citizen of What Cour	
with the	ral Di	5 ///7 N. K//amont Street 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D	21216 eccedent of Hispanic Origin? (U5/	can Indian, Black,
er death	Funeral	1 Never Married 2 Married Armed Forces? If Yes, 1 Yes 2 No 1 Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes	specify Cuban, Mexican, Pue	rto Rican, etc.)	White, etc.	21
hours aff natural	ed by	or Dates:	es 2 No specify: Usual Occupation (Give kind of working life, DO NOT use r		Specify: 16b. Kind of Business/li	ndustry
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215-0 e filed w tal Hygic ked othe nt, the N	Be Co		1 2 .		Maiden Surname)	-
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	ToE	19a. Informant's Name/Relationship (Type, Print)	dress (Street and Number of			
re, M s 1 and 2 f Health If item 2 er traun		Octavia Smith Grandmother 16 909 D 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State crematory or other		Ap+ A Date	Baltimore N 20c. Location - City or	10 21239 Town, State
Itimo it. Pages rtment o ortant: J		A Depotion 5 Other Secritive	1 No -11 0	-25-10	Baltimore	, Maryland
		1 0 0000	e and Address of Facility Ann C. Gree Himore Mat	1/3K\/ALJ 1=	110 (217)	10e, 5151
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the railure. List only one cause on each line. Immediate Cause (Final disease a. Sudden infant death s			est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):	Jindi Ome (DIDO)	<u>, </u>		
	niner	Sequentially list conditions, if any, leading to immediate cause. Ever Underlying Cause (Discovery or injury that initiated C.				
uted nd ransit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.				
60, ate be executed hysician and burial - transit	Medical	☐ AMENDED ☐ AMENDED Z3a,27,per ME g910	12/16/10 TT			
Ox 6876 eath certificate attending phy for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal of		nancy	23d. Date of delivery Month Da	ay Year
Box 687 ne death certifica the attending p	Physic	g Unknown	(Specify)			
P.C	含	<u> </u>	rlying cause given in Part I.		obacco use contribute to the 2 No 3 Proba	
of Vital Records, Ping Physician: The law requires ther this certificate has been sign pineral director, page 2 should be to	Completed			24a. Was autop	sy prior to co	opsy findings available impletion of cause of
tal Rec		25. Was case referred to medical	26.Place of Death (Check	1 Yes		2 No
f Vita Physicia er this ce	To Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 27. Manner of Death 28a Date of Injury 28b. Time of Injury	DOA Other Nurs	ing Home 5	Residence 6 Other:	
ion of tending Pheath.	ation:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe r	now injury occurred	
Division pital or Attendii ours after death. teral Director: /	Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, fa	ctory, office building, etc.	28f. Location (S or Town, S	Street and Number or Rura tate)	al Route Number, City
	ल	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurred a one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation,	at the time, date and place, an	d due to the cause at the time, date a	e(s) and manner as stated	i.
To To con	¥	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Monti	
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		September 20, 20	10
Can		Melissa Brassell, MD Assistant Medical Examiner 111 Penr	Street, Baltimore, MD	21201		
Sta Registr	ar	CEDDO 66461 6	2			

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5,10e,17&18 PerFH G908 1/25/10Jh
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 MYSZKOWSKI 0625 RYST YN A Sep Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Howard** 4b. City, Town, or Location of Death Examiner Columbia **Howard County General Hospital** 5. Soci**g 198** uri**u 18** uri **24** 11 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Country) Poland 76 (MONTO P16, 1933 Director Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County within 72 hours after death with the Maryland Important, If item 27 Is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the <u>Medical Examiner must be notified at</u> 10c. City, Town or Location 10d. Inside City Limits Director **Ellicott City** MD Howard 1 ☐ Yes 2 🕽 No Og Street and Number 8255 Maple Rock Dr. 10f. Zip Code 10g. Citizen of What Country? Funeral 21042 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian. or i Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Nidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Data Entry Operator 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important; If item 27 is marked other tha Communications Be t) Wincenty Strusinski Vincenty Strusinska 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown Stanislawa Synakowska 19a. Informant's Name/Relationship (Type, Print) 19b**97aff (s.** Address (Street and Number or Rural Route Number, City or **8256** Maple Rock Dr. Ellicott City, MD 21042 Zygmunt Myszkowski son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory, LLC Sep 23, 2010 Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Simature of Funeral Service Dicerisee 22. Nam State (Fisher at Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic cardiovascular Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a nonsequence or; attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav Year Other (specify) 1 Yes 2 9 Unknown ed by the a detached f 9 Unknown Division of Vital Records, P.O. signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 □ No 3 □ Probably 4 □ Unknown cate has been signated by page 2 should b 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of death? After this certificate 1 Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗓 No မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 D ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 defining righting r (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D69106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Apt. 440 Hanover 7804 SAMIT 31. Date filed (Month, Day, Year) State

Registrar

		For State Registrar			State o	f Maryl	and / Dep Ce	artment of rtificate of	Healt Deat	th and M th			/	0	29858
	,	1. Decedent's Name (First, Middle, Last) 2. Date of Death										3. Time of Death			
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Examin	er	** * * *													
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ath wi	Funeral Director	6500 Ri	ggs Ro	_	2. Was Dece	dent Ever in	IIS 13	Was Decedent of	0783		cify Ves or No-		US		1
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nd 2 sh lealth ar m 27 is ner trau		19a. Informant's Name/Relationship (Type, Print) Larry Faulk/friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 4713 Wisconsin Acenue NW Washington										ngton,	DC	20016	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in state												wn, State	
permit Depart Import any inj		21. Signature of Funeral Service Licensee Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201													
			irt failure. List	only one	ations that o	ch li n e				h as cardiac o	r respiratory ar	rrest,			Approximate Interval Between
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To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	_	23b. Was decedent in the past 12 1 Yes 2 [g Unknown	months?	230	i. If yes, out 1 Live I 4 Pregi 9 Unkn	Birth 2 🗌 I nant at time	Fetal death 3	Ectopic pregna Other (specify)	псу				23d. Date o Month		ery Day Year
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Mogth ZU/ U 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mandarin Hospice House Anne Arundel Harwood 1 Year If Under 24 Hrs Social Security Number 6. Sex If Under 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min (Month, Day, Yea Country)
Maryland Director 213-30-3428 Feb 16 Usual Residence of Decedent 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene.

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State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 23a. Par 1. Enter the sease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate use (Final disease or contition resulting in death) Onset and Death Physician/ Medical Due to (or r a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician; The law requires 2. No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes HOUTE Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 🗌 only one) Signature and title of certifie 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

SEP 2 3 2010

DHMH 17 Rev 7/2009

Box 68760

P.O. I

Records,

Division of Vital

NNAPOLIM DZ1401

leted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Physician/ Rexanna Lee Moser Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs
Months Days Hours Min. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Oct 18, Year Maryland 1 M 2 V Director 1949 218-50-3306 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Washington 1 Yes 2 No Boonsboro ö 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? 6607 King Road Funeral 23a 21713 USA items ? within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. ō ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: "natural", 3 Widowed 4 X Divorced white Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha home care aide healthcare Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe Austin Henry Lee Moser Carrie Mae Moser permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosanna Swann/daughter 7750 Pomfret Road LaPlata, MD 20646 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 21, Signa konali State Anatomy Board 655 W. Baltimore Street MD Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause Final Afavition Onset and Death Ph sician/ disease or condition Medical resulting in death) Examiner DISEASE prenen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 use as the IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy for 1 in the past 12 months?
1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death g Unknown 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an las l autopsy performed death? 1 Yes 2 No certificate 1 Yes 2 No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No မ ER/Outpatient 3 DOA 1 Inpatient 2 M 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 🔼 Natural 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 14656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 90 MECUSTOWN MD KOAN Manya

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month,

Day, Year)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 16, Physician/ 2010 ΡМ September John Francis McGee, Sr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore <u>Towson</u> Gilchrist Hospice 9. Birthplace (State or Foreign Country) Mary Land If Unde 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Yea 4/18/24 Days 1 XM 2 1 Director 216-16-9705 86 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Parkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with ti Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a o Funeral 5 Lauriann Court 21120 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 万 Yes 2 □ No If Yes, Give Year or Dates.1943-45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Completed 3 ☒ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Stee1 Iron Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Annie Kidd Joseph McGee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lauriann Ct. Parkton, Maryland Daughter Robin Iachini / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State any injury or Loudon Park Cemetery 9/20/10 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, or co shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a sequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IE FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month 1 Yes 2 D 2 No signed by t Id be detach Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes peen Chronic Kidney Duscose 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform After this certificate 1 🗌 Yes 2 🗌 No 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner?

1 Yes 2 XNo Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 잍 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated The Death of Administration of the Death of Administration and the Third State of the Casarda and Country and the Third State of the Casarda and Country and the Third State of the Casarda and Country and Countr only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Villannery,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Brent R. McClain Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner BARTIMORE WACHINGTON MEDILAR 15UIZNIE BFINE If Under 24 Hrs. If Under 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours 1 AM 2 Months Min 07/15/1954 217 58 1158 56 Maryland Director Usual Residence of Decedent or 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Anne Arundel Baltimore Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21225 5409 Chatham Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Yes Give 3 🖔 Widowed 4 🗆 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Superfresh Food Store Maintenance 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles W. McClain Catherine Sponsal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 - 15th Avenue Baltimore, Maryland 21225 Janet Purcell or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Baltimore, Maryland 09/20/2010 injury 4 Donation 5 Other (Specify) Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 rununus a Part 1. Enter the disease or complication shock, or heart failure. List only one cause or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ HEUMBHH Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner ng physician and as the burial-transit requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No be detached for Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available 24a Was an Hospital or Attending Physician: The law autopsy performed Yes 2 prior to completion of cause of death? After this certificate has page 2 1 Yes 2 No 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖪 No Hospital 1 \square Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29d. Date signed (Month, Day, Year) 17 2010 ess of person who completed cause of death (Item 23a) (Type, Print) 301 2. Registrar's Signa State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 8:35 P.M Physician/ Lawrence A. McCormick September 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Glen Burnie North Arundel Health & Rehab. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 89 0971271921 Ohio 217 05 2625 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director Baltimore Anne Arundel 1 Yes 2 X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 U.S.A. 5205 Disney Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 XYes 2 No Black, White, etc. 1 Never Married 2 Married XYes þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced WW II Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12th College (1-4 or 5+) Electronics Sales Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James H. McCormick <u>0</u> Margaret Duffy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21225 5205 Disney Avenue Emma McCormick / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Glen Burnie, Maryland 09/20/2010 Glen Haven Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. Ritchie Highway Baltimore, Maryland 21225 Inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or shock, or heart failure. List or Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or linjury that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) the page 2 should be detached Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy hours after death. Ineral Director: After this certificate Yes 2 No 1 ☐ Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 Pending 2 🗌 No Accident Investigation

Division of Vital Records, P.O. Box 68760 Hospital within 24 hours a To the Funeral I

> State Registrar

Medical

Suicide

29b. Signature and title

4 Homicide

29a. Certifier

6 Could not be

determined

completed

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Proceedings Nurse Procedure: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

eath (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Datę signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month 09 7:19 PM **Physician** 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital N/A **Baltimore City** If Under 1 Year If Under 24 Hrs.
Months | Davs | Hours | Min. 5. Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 10/14/1976 9. Birthplace (State or Foreign **Funeral** 33 Maryland 218 86 1553 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County , or items 23a or 28a-f show miner must be notified at Director 1 Yes 2 X No Marvland Anne Arundel Linthicum 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code U.S.A. 417 Sudbury Road 21090 Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify. þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 7 Is marked other than "nature traumatic event, the Medical (Give kind of work done d life. DO NOT use retired) College (1-4 or 5+)
4 years Elementary/Secondary (0-12) John Hopkins Hosp. Maintenance Planner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anthony Matuszewski Nancy Jorgensen ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other trainonce. Linthicum, Maryland 21090 Nancy Matuszewski / Mother 417 Sudbury Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 09/20/2010 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Signatur Fylleral Service 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) pro /Medical Due to (or as a consequent of Examiner Sequentially list conditions, if any social to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of or Attending Physician; The law requires that the death certificate be executed J physician and as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? ģ Month Day Year Pregnant at time of death 5 Other (specify) detached 2 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 2 🗌 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home 2**X** No Hospital: 1 Inpatient 2 🗆 ER/Outpatient 1 🗌 Yes 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) ည After this 27. Manner of Death 1 Natural . Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho

To the Fune

completely f (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, SEP 2 3 State Registrar

DHMH 17 Rev 1/2001

(3)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Saptember 8:35 AM POLING 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Baltimare HARDOR HOSDITA N/A If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months 1 X M 2 □ F 87 234 30 2205 02/20/1923 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code U.S.A. 21225 315 Frankle Street 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ▼Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 X Married 2 No 1 ☐ Yes 2 X No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced WW TT White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Trucking Truck Driver 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Worthington Poling Leona Grace Simon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21225 315 Frankle Street Lorene Poling / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐xBurial 2 ☐ Cremation 3 ☐ Removal from State 09/17/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Acute INFARCTION HYOCARDIA dAY disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Case to for as a consequence off Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown

Physician /Medical Examiner

permit. Pages 1 and 2 s
Department of Health as
Important; If item 27 is
any injury or other trau

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

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Certification: To

Medical

d 2 should be filed within 72 hours after death with the Man th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f st traumatic event, it is Medical Experimental to confid

3altimore, Maryland 21215-0036

sician and burial-transit attending physician for use as the burial signed by the a cate has been si page 2 should b director, this After this

law requires that the death certificate be executed

The

Box 68760,

P.0.

Division of Vital Records,

OBSTRUCTIVE PULMONARY CHRONIC

1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv performed

1 ☐Yes 2 ☑No 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 ☑Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

RES 000

September 14,2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MASRI, 3001 South HANOVER STREET, BALTIMORE, M.D.

State Registrar



To the Hospital or Attendia within 24 hours efter death. To the Funeral Director: A completely filled in by the fu

iter dea∷h.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 20, Physician/ ^{Year} 2010 Frances Elizabeth Peregoy September 1:26 A.M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Carroll Hospital Center Westminster Carroll Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 💥 F Virginia Months (Month, Day, Y 75 Yrs. Director 215-30-4338 6, Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural" as isome. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No Carroll Finksburg Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 1453 Wesley Road 21048 America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black White etc. 1 Never Married XX Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Daycare Provider Children Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John William Lentz Hazel Evelyn Shipe permit. Page 1 and 2 should to Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond M. Peregoy, Sr. (Husband) 1453 Wesley Road, Finksburg, Maryland 21048 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sep. 23, 1XXBurial 2 ☐ Cremat cemetery, crematory or other place) ō on 3 Removal from State injury 4 ☐ Donation 5 ☐ Other Specify) Evergreen Mem'l Grdns 2010 Finksburg, Maryland 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. Signature of Fundal Lenice Licenses any in once. 3296 Charmil Drive, Manchester, Maryland 21102 t 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Comarshive Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and defached for use as the burial-transit thero Scleros that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Helletter. treque 1 ☐ Yes 2 →No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 뎯 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, this 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State Registrar

within 24 hours a

29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

erson who completed cause of death (Item 23a) (Type, Print)

🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Contifying Russis Practioner To the best of my knowledge, death occurred at the time, date and plane, and due to the navestall and increase as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #30 per DVR g907 9/23/10/ TT State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joan C. Redd Month 08-28-2010 3:17 AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours (Month, Day, Year) 1950 Washington DC Director Yrs 60 579-68-0678 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1y Yes 2 ☐ No Fort Washington PG Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20744 US 8904 Black Briar Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?
1 ☐ Yes 2 X No Black White etc. 1 Never Married 2X Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: 3 Divorced Black Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Small Business Admin. 12th Personnel Specialist permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Richard Cooke Alice Edelin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Redd Jr. 8904 Black Briar Ct. Ft. Washington, MD. 20744 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 09-04-2010 Brentwood, Maryland Lincoln Cemetery 21. Signature of Funeral Service Lie 22. Name and Address of Facility Dunn & Son Funeral Home 5635 Eads St. NE, Wash D 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death
5 years Immediate Cause (Final Physician/ Metastatic Uterine Cancer disease or condition Medical resulting in death) less than Examiner 1 week Thrombotic Thrombocytopenia purpura Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypertension Diabetes Mellitus Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No page 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 🗆 XNo 1 Yes Other: ည 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death To the Funeral Director. / completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 301 2010 D0068681 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20910 1500 Forest Glen Road Silver Spring, MD Charu Maheshwary, MD32. Regis 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day 15, Physician/ Ž₀10 Helen Mary Ryan September 5:37 p.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Baltimore Timonium If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Aug. 30, 1932 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days 1 □ M 2 🕱 F Hours Maryland Yrs Director 78 214-30-3977 Usual Residence of Decedent items 23a or 28a-f shov er must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 XNo Harford Abinadon Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 Crosse Pointe Court 21009 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or iter Black, White, etc. ğ 1 X Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 045mber 15, 2010 Baltimore, Marylahd 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Me ical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Bus Driver Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be file tment of Health and Mental tant. If item 27 is marked of ဝ William Carroll Ryan Anna Augusta Benser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Crosse Pointe Ct., Abingdon, MD 21009 James Ryan / Son september 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gdn. 9-21-10 Bel Air, Maryland permit. 22. Name and Address of Facility McComas Funeral Home, 1317 Cokesbury Road, 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Telan Ky and Box 68760 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan performed' 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital Other: 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 M Other (Specify) Manner of Dea Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred, injury 5 Pending Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 1 29c. License number 30. Name and address of person who completed cause of death (Item 23a) [Type, Print) 2300 SEP 2 3 2010 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 45 ese DOOL Ini Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Randallstown Seasons Hospice If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min (Month, Day, Year) Dec 10, 1932 Country Virginia Director 224-36-1576 77 Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Baltimore N/A Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 U.S.A 1955 West Lexington Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Maryland 21215-0036 Black If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Self Employed Elementary/Seconday (0-12) College (1-4 or 5+) Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Virginia Reese Linwood Reese Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1955 West Lexington Street Baltimore, Maryland 21223 Michael Reese Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Catonsville, Maryland 09/22/10 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 21. Si na Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P 300 Futaw Place Baltimore, Md 2 Rant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). sician and burial-transit Exami Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnam 9 ☐ Unknown signed by the be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has page 2 after death. Director: After this certificate 2 No Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 No ☐ Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Funeral I Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

within 2 To the I

State Registrar (Check

only one) 29b. Signature and title

DHMH 17 Rev 7/2009

who completed cause of death (Item 23a) (Type, Print)

32. Registra

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Day, Year)

29c, License number

TAFI

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar 1. Decedent's Name (First, Middle,	Last)		Cei	incate o	Deain		2. Date of Dea	ath	010	3. Time of Death
Physi	ician edica		Marie S.	mmon	S					Month eptembe	Day	Year	11:55 AM
and the same of th	mine		4a. Facility Name (if not institution,	give street and nu			4b. City, Town		of Death		4c. Count	y of Death	
			Seasons Hospi					dallsto				Ltimore	
Fune Direct			216-34-5772	6. Sex 1	7. Age (In yrs	s. last birthday) 71 Yrs.	If Under 1 Ye Months Day		Min.	8. Date of Birt	th 1939 ⁽⁷⁾	9. Birth Cour	place (State or Foreig htry) MD
nd how at		_ h	Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town or Lo	cation						10d. Inside City Limits
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with s 23a		Funeral Director	3206 Ridgeway Plac	e			212	244				USA	
death item	ı		11. Marital Status	12. Was De Armed F	cedent Ever in Forces? s 2 X No	U.S. 13. V	Vas Decedent of f Yes, specify C	f Hispanic O Jban, Mexica	rigin? (Spean, Puerto F	cify Yes or No- Rican, etc.)		ce - Ameri	
after all, or sami	:	d by	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Moivorced	ed 1 Yes	live	1	☐ Yes 2 🛚	No Specif	y:		Specif	A.F.	ican-America
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ary hould and Ma s mar		T	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Stre	et and Numl			r, City or Town,	State, Zip	Code)
, IVI			Angela Wilson/ Daug	hter		3206	Ridgeway	/ Place	. Winds	or Mill,	MD 21244	, 	
Dalfillnore, Dermit, Page 1 and Department of Hea mportant: If item any injury or other	1		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 Removal fro	m Ctoto	. Place of Dispo cemetery, cren	natory or other t	olace)		ate	20c. Location		
t. Pag trmen rtmen rtant:			4 Donation 5 Other (S)	pecify)	Met	tro Cremat			9-16-2		Baltimon		ryland Balto. To.
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_		+	23a Part 1. Enter the disease, or	complications tha	t caused the de						MD 21137 rest,	<u> </u>	Approximate
Physicia	an/		Shock, or heart failure. List of Immediate Cause (Final	nly one cause on	each line.	astati(Interval Between Onset and Death
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sertificate b iding physics ise as the b		D L	IF FEMALE:	_ u									
h cert tendir r use	1		23b. Was decedent pregnant in the past 12 months?	1 ☐ Līv		etal death 3	Ectopic pregn	ancy				ate of deliv	,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	1.9	Physician/ivi	1 Yes 2 No	4 ☐ Pre 9 ☐ Un	egnant at time o known	of death 5 ∟	Other (specify,				i N	onth	Day Year
that the red by detac	å		Part II. Other significant condition	ns contributing to	death but not	resulting in the u	nderlying cause	given in Par	t 1.	23e. Did to	obacco use con	tribute to t	he cause of death?
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Hosp 24 hou Fune	19	Medical	(Check 2 L Medical Ex	Physician: To the caminer: On the b	asis of examina	tion and/or invest	igation, in my op	inion, death	occurred at	the time, date a	nd place, and di	ue to the ca	luse(s) and manner sta
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			only one) 3 Certifying 29b. Signature and title of certifier 30. Name and address of person w 31. Date filed (Month, Day, Year)	ho completed ca	use of death (It	em 23a) (Type, P	rint)	(1) A	7, 7	-103	Ba	n m	or NO.
			21 Data filed (Manth Day Vans)	17 . S . 1Ca	Joyal V.	SCIMP	100000	7"	v · J		,		. /
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Luaene 2010 16 Medical 4a. Facility Name (if not Institution Examiner 4c. County of Death ledica Ba HIMOY Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🛛 M 2 🗆 F Months Hours June 19 Year 1943 Massachusetts Director 023-32-9006 67 Usual Residence of Decedent Show 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland at Director ral", or items 23a or 28a-f s Examiner must be notified 1 🛚 Yes 2 🗆 No Maryland Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21214 2713 Bayonne Avenue **USA** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married X Yes 2 ☐ No FYes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene.
ant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Business Consultant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Eugene Schrader Sr. Marie Rose McInerny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Schrader / Son 272 Garvine Mill Road, Fawn Grove, PA 17321 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of ☐ Burial 2 🛭 Cremation 3 ☐ Removal from State Important: I any injury o 4 ☐ Donation 5 ☐ Other (Specify) <u>Hilltop Service Corp:</u> 9-22-10 Towson, Maryland Signature Funeral Service Licenses ²² Name and Address of Facility

McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final tion Physician/ Medical resulting in death) as a consequence of Examiner onb Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjur) that initiated events the attending physician and hed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death ☐ Pregnam.
☐ Unknown Yes 2 No g Unknown signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No □ Inpatient 2 □ ER/Outpatient 3 □ DOA Certificate: To 27. Manner of Death 28c. Injury at work? 1 \quad Yes 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Director: After (Month, Day, Year) 1 Natural 5 Pending 2 🗌 No Investigation 6 Could not be Accident Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completed filled in by determined Hospital Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) 435H 100651 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Christan Ha
31. Date filed (Month, Day, Year)

2. Registrar's Signature

10 N. Greene St. Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician pharpe /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Healtha Kehab Date of Birth (Month, Day unk **Funeral** Hours Days Year Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 1 ☐ Yes 2 No Director Anne Arundel Edgewater MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or USA 21037 144 Washington Road тs 23a Funeral unk Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items dical Examiner m 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or ite ury or other traumatic event, the Medical Examine. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 Widowed 4 Divorced Completed unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 144 Washington Road Edgewater, MD South River Health & Rehab Ctr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🖺 Other (Specify) in *tate State and Address of Fourth 655 W. Baltimore Street 21 Signature of Euneral Service ROnald rector Baltimore, MD 21201 sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on eath Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, saving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence off Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 3 Probably Unknown 1 TYes 2 No page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 2 No Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Varsing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hou To the Fune completely fi (Check only one) and manner stated. To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) errolet drive

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

EP 2 3 2010

	1	For State Registrar	State of Mary		partment of <i>ertificate o</i>		Mental Hy	•									
Physician		1. Decedent's Name (First, Middle, La DOLORES , C	ATHERINE				2. Date of De Month	Dav	Year	3 Tirke of Death							
/Medical Examiner		4a. Facility Name (If not institution, gir	ve street and number)	,	4b. City, Town,	or Location of Dea		4c. County		A - AAPM							
Funeral Director		5. Social Security Number 6. 8		<i>yrs. last birthda</i> Yrs.		r If Under 24 Hrs		th ay, Year) 4/1929	N/A 9. Birthp Coun Mar	lace (State or Foreign try) and							
r 28a-f show		Usual Residence of Decedent 10a. State 10b. County Maryland Anne	Arundel	e. City, Town or Balti					10	0d. Inside City Limits							
ath with the Mar 23a or 28a-f sl 11st be in tiffed		10e. Street and Number 306 Seward Ave			10f. Zip Code	21225		10g. Citizen of V									
rs after de	1	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Movidowed 4 □ Divorced	12. Was Decedent Ever i Armed Forces? 1	in U.S. 1	3. Was Decedent of If Yes, specify Cu		Specify Yes or No rto Rican, etc.)	14. Rad Blad Specify	e - Americ ck, White, e								
		15. Decedent's E (Specify only highest gr.	ducation ade completed) College (1-4or 5+)	(Gi	cedent's Usual Occ ve kind of work don e. DO NOT use reti omemaker	upation e during most of wo ed)	orking	16b. Kind of Bu	usiness/Ind	•							
	0000	17. Father's Name (First, Middle, Last	William Deh		Onlemaker		me <i>(First, Middle)</i> arbara Aj	, Maiden Surnam		· · · · · · · · · · · · · · · · · · ·							
and 2 shousalth and N 27 is mailer traumal		19a. Informant's Name/Relationship	· · · · · · · · · · · · · · · · · · ·	I .	Seward			er, City or Town, ore, Man									
permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	nemoval from State		position (Name of rematory or other position)		Date /24/2010	20c. Location -	•	_{wn, State} Maryland							
permit. Departr Importa any inju		21. Signature of Funeral Service Lice		Ms	22. Name and Add		Gonce Fun nway Bal			e, P.A. land 2122							
rificate be executed Type Indicate be executed Springly Indicate as the burial-transit as the burial-transit Aledical Examiner		23a. Int. Enter the disease, from shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. COPD	IALL CEnsequence of): FIBRI	LL CARC	INOMA		rrest,		Approximate Interval Between Onset and Death							
nat the death certific d by the attending retached for use as Physician/Mec	by Physician/in	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√2√No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ f 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	B ☐ Ectopic pregna Dother (specify)	ncy			te of delive	ry Day Year							
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		3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Sp	ecify)			City or Tov										
ithin 24 hou of the Fune of the Fune ompletely fill		one)	ysician: To the best of my niner: On the basis of exan and manner stated.	knowledge, de mination and/or	ath occurred at the investigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time,	date and place,	anner as st and due to	tated. the cause(s)							
with Con		29b. Signature and title of certifier	RESIDENT		RES	se number		29d. Date signed		Day, Year)							
	5	0. Name and address of person who HEENU SHEELA, 3	001 SOUTH HI	ANOVER	STREET	BALTIM	ORE, MA	RYLAN	D, 21	1225							
State Registrar	3	SEP 2 3 2010	32. Registrar's Si	nature	Es .												

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ VIRGINIA SMITH SEPTEMBER 18 2010 7:40 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FOREST HILL HEALTH & REHABILITATION HARFORD 9. Birthplace (State or Foreign Country) NC FOREST HTL 5. Social Security Number **Funeral** . Age (In yrs. last birthday If Under 24 Hrs. 8. Date of Birth 1 🗆 M 2 🕮 Hours Min 240-52-3151 75 Months Director 193 Usual Residence of Decedent fshow 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Harford Forest Hill or 28a-f 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 109 Forest Valley Road 21050 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. "natural", If Yes, Give 3 Divorced Specify: White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once." Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Enviromental Janitorial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Rutherford Alice (unkn) 19a. Informant's Name/Relationship (Type, Print)
Virginia Billing / 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Daughter 402 Apt. A, Meadowwood Drive, Edgewood, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery, crematory or other place) Final Journey Crem. 4 ☐ Donation 5 ☐ Other (Specify) 19/21/2010 Woodbine, MD 21. Signature of Feneral Service Litensee Dorota Marshall 22. Name and Address of Facility Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ JUT hen disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a someoquenes or). attending physician and for use as the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Month Day Year ed by the a 1 ☐ Yes 2 ☐ Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy certificate performe death? Yes 2 No 1 ☐ Yes 2 No To the Funeral Director: After this certifics completed filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 Tes 2 🗌 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifie. 29c. License number 29d. Date signed (Month, Day, Year) D32299 wol Septembor 21, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR DAVID DUNN- 615 MACPHAIL ROAD -BEL AIR , MD 21014

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER 20. WENDY JILL SPECTOR 2010 6:59 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12001 HARTLEY MILL ROAD GLEN ARM BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Days Hours Min 1 M 2 L 1070471955 Director 213-68-0625 54 MD Usual Residence of Decedent 28a-f shov 10a. State 10h County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD BALTIMORE GLEN ARM 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 12001 HARTLEY MILL ROAD 21057 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 ☐ Widowed 4 ☐ Divorced WHITE Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry t of Health and Mental Hygiene. If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 4 TEACHER **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be CLAIRE SANFORD HERSHFIELD other traumatic REISSIG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEONARD SPECTOR/HUSBAND 12001 HARTLEY MILL ROAD, GLEN ARM, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 0 1 🗆 Burial 2 💢 Cremation 3 🗔 Removal from State permit. Page Department of Important: If any injury or CARROLL CREMATION, INC: 09/24/2010 → Donation 5 ☐ Other (Specify) HAMPSTEAD, MD Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician, Ovalian Medical resulting in death) Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) that the death certificate be executed Cause (Disease or lingury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant Was deceue... in the past 12 month 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ ate has been signed by the atte page 2 should be detached for Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform After this certificate Yes 2 No 1 Yes 2 No å 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: 2 |@ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending 2 ☐ Accident 3 ☐ Suicide Investigation

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires twithin 24 hours after death.

To the Funeral Director: After this certificate has been sign iours after death.

Neral Director: After this certific filled in by the funeral director,

> address of person who completed cause of death (Item 23a) (Type, Print) 9114 Philadelphia, Rd. Ste 208 *A*shkan Bahrani 31. Date filed

6 Could not be

determined

Homicide

29b. Signature and the of certifie

29a. Certifier

(Check

Baltimore, MD 21237

28f. Location (Street and Number or Rural Route Number, City or Town, State)

20

State

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar's Signa

Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Colate of Walyland / De	ertificate of De			Reg. No.		
	Physicia Medic		1. Decedent's Name (First, Middle, Last)	TOPP			2. Date of Dea Month September	Day Year	3 Tirng officearh 7	
امید	Examir	ner	4a. Facility Name (if not institution, give st Univ of Maryland	medical Center	4b. City, Town, or Lo Bultimore	-	' '	4c. County of De	path	
i	Funeral Director		70.3 40 40 10 7	M 2 □ F 7. Age (In yrs. last birthda		f Under 24 Hrs. Hours Min.	8. Date of Birth (Marte, Pay		Birthplace (State or Foreign Country)	
	laryland 3a-f show ified at	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Part More 10e. Street and Number 10e. Street and Number 10f. Zip Code							
	with the N 23a or 28 ust be not	Funeral Dir	10e. Street and Number / Cooperative		10f. Zip Code 2/2	12		10g. Citizen of What C	1 V Yes 2 No	
9600	nit. Page 1 and 2 should be filed within 72 hours after death with the Manyland artiment of health and Mental Hygiene. artiment of health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.e.	<u>₹</u>			3. Was Decedent of Hispa If Yes, specify Cuban, N 1 Yes 2 No S	anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	nerican Indian, ite, etc.	
21215-0036	within 72 ho giene. er than "nat , the Medica	Completed	15. Decedent's Edu (Specify only highest grade Elementapy/Seconday (0-12)	completed) [(Gi	cedent's Usual Occupatio ve kind of work done durii DO NOT use retired)	on ng most of worl	king	16b. Kind of Busines Cinstru	s Industry	
Maryland	ld be filed Mental Hy arked oth atic event	To Be	17. Father's Name (First, Middle, Last) Claude Topp		18	1/2	ne (First, Middle, N	Naiden Surname)		
	and 2 should Health and Me em 27 is mar ther traumati		199 Informant's Name/Relationship Type Romaine Topp	Mother 10	ailing Address (Street and	Number or Ru	al Route Number,	City or Town, State, 2 Ye, Mury 1	und 21212)	
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ott		20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State 20b. Place of Dis	position (Name of rematory or other place)	9/2	Date 7/10	20c. Location - City of	or Town, State	
Ball	permit. Page Department Important: any injury o	(S	21. Signatura of Funeral Service Licensee	Treene	22. Name and Address o	Greene	FS 3	1905 YUXIS	2/2/2	
-J	hysician/	100	23a. Part 1. Enter the disease, or complic shock, or hear failure. List only one Immediate Cause (Final disease or condition	cause on each line.	nter the mode of dying, si	uch as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death	
	Medical Examiner	-E	resulting in death) Sequentially list conditions, b.	Due to (or as a consequence of): Me tastatic	throat Ca	ncer			lyr	
	ecuted and transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as a consequence or).						
8760	tificate be executed ng physician and as the burial-transit	Medical E	resulting in death) Last	Due to (or as a consequence of):						
. Box 687	± 50 €	T I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of d	elivery Day Year	
s, P.O.	res that the signed by d be detact	۵	Part II. Other significant conditions cont	ributing to death but not resulting in the	underlying cause given i	in Part I.			to the cause of death?	
Division of Vital Records,	he law requ te has been age 2 shoul	Completed	Brain metastasis	•			24a. Was ar autops perforn	24b. Were any prior to death?	utopsy findings available completion of cause of	
Vital	ysician; i s certifica director, p	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 Pinpatient 2 ER/Outpati	_ Other:	of Death (Chec		nce 6 Other (Spe	es 2 🗹 No	
on of	ath. r: After thi le funeral	Certificate: 1	27. Manner of Death 1	28a. Date of injury (Month, Day, Year) 28b. Time injury	of 28c. Injury at work?		28d. Describe ho		спу	
DIVISI	m .a — TO									
	ine nospi in 24 hou the Funer ipleted fill	Medical	Check 2 - Medical Examiner	an: To the best of my knowledge, death: On the basis of examination and/or inversationer: To the best of my knowledge	estigation, in my opinion, d	eath occurred at	the time, date and	I place and due to the	cause(s) and manner stated	
	vith Co		29b. Signature and title of certifier	Resident Physicia	29c. License nur	nber 32349		9d. Date signed (Mont		
			30. Name and address of person who com John Siu M.P. 2z	pleted cause of death (Item 23a) (Type,		,				
	State Registra	e r	31. Date files (Month, Day, Year) SEP 2 3 2010	32. Registrar's Signature						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Charles Taylor JR 20 2010 9:15AM ajember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death <u>Randallstown</u> Baltimore Seasons Hospice If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1 ▼M 2 □ F Hours 218-18-8914 85 Director 22-1925 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll. Finksburg 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21048 USA 2004 Deerpark Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: African-American Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore Country Club Hospitality Manager 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence Bagwell Charles D. Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2004 Deerpark Road, finksburg, MD 21048 Terry Shoats/Daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-28-2010 Owings Mills, MD Garrison Forest Veterans Signature of Funeral Service Licenses 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randalltown, MD 21133 23a. Part 1 cnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Interstitial Lung Disease Physician/ END Stage disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, Examiner thany leading to immedia cause. Enter Underlying Cause (Disease or linjury Due to the es a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at Id be detached fo 4 ☐ Pregnam a 9 ☐ Unknown 1 ☐ Yes ∠ □ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Director: After this certificate d in by the funeral director, pag 2 No 1 Yes 2 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other:
4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Tes 2 🗆 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

Rajapakel, M.D

upanseN.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0057465

5 milh N-5-203-Baltimore, MD21204

9/22/10

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 29879 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day to 2010 Physician/ 16:14 DM R banczyk Rokembe Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore Baltimore niv of Maryland Medical Center If Under 1 Year If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. 1 🔀 M 2 🗆 F Months Hours 106-38-8042 61 Director 13, pril 1949 New York Usual Residence of Decedent or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director NY Ontario Wayne 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ems 23a or r must be r Funeral 14519 USA 6228 Knickerbocker Road ural", or items a within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force ģ 1 Never Married 2 Married ☐ Yes 2 🔀 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates Specify: "natural" 3 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Computer Software Developer 10 years other permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event; To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thaddeus Urbanczyk Katherine Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6228 Knickerbocker Road, Ontario, New York 14519 Susan Ann Urbanczyk Wife Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State September Baltimore, Maryland Bayview Crematory 4 Donation 5 Other (Specify) 2010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Agriculture and Address of Pacifity

Connelly Funeral Home Of Dundalk, P.A.

7110 Sollers Point Road, Dundalk, Md.

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Connelly Funeral Home Of Dundalk, P.A.

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Connelly Funeral Home Of Dundalk, P.A.

Agriculture and Address gneture of Funeral Service Leny e Approximate Interval Between Onset and Death embolism Physician/ Monary disease or condition Medical resulting in death) Due to (or as a conse wence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death). Examine burial-transit The law requires that the death certificate be executed 24 and resulting in death) Last attending physician Physician/Medical agulp Division of Vital Records, P.O. Box 68760 IF FEMALE: Se 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Yes 2 Unknown the be detached signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed has this certificate 2 To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 🛂 No I ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After t 1 Natural 5 Pending death. 1 Yes 2 No Accident Suicide Investigation hours after death uneral Director: / Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined within 24 hours a

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completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

3 we and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARINA BARAKOVA GORE 22 (

GORE

knber 20th 2010

Greene Strat Bullinge MD

	-	For State Registrar	State of Mary		partment of F ertificate of a			leg. No.	110 2988	(
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Brian Cha	arles Va	nce			2. Date of Dea Month Septemb		2010 3. Time of Death 4:16 aw	1
Examin		4a. Facility Name (If not institution, give s St. Thomas Moore		ome		r Location of Deal	th	4c. County Prin	ice George's	
Funeral Director		5. Social Security Number 6. Sex 250-67-4197	7. Age (In 2 7. Age (In 2 23	n yrs. last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min		, Year) 986	9. Birthplace (State or Foreig Country) CA	m
Maryland a-f show	ctor	Usual Residence of Decedent 10a. State MD St. Mar		c. City, Town or		harlotte	Hall		10d. Inside City Limita 1 ⊠ Yes 2 □ No	
3a or 28	al Director	10e. Street and Number 37760 Indian Cre	ek Drive		10f. Zip Code 20	0622		10g. Citizen of \	What Country? USA	
72 hours after death with the Maryland natural", or items 23a or 28a-f show deat Evan, item to it will have	d by Funeral	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐Yes 2 No If Yes, Give Year or Dates:	in U.S. 1	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 KQ No		Specify Yes or No- to Rican, etc.)	Specify Specify	ce - American Indian, ck, White, etc. y: Whi'te	
	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	1 (G	cedent's Usual Occup ve kind of work done o. DO NOT use retire Car Mecha	during most of wo d)	orking		usiness/Industry	
1 and 2 should be filed within Heath and Mental Hygiene. em 27 is marked other than ther traumatic event, the files	To Be C	17. Father's Name (First, Middle, Last) Charles C. Vance				18. Mother's Na Elvi	me (First, Middle, Munoz A	Angelas		
s 1 and 2 should f Health and Mer tem 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty Charles C. Vance			illing Address <i>(Street</i> 160 Indian				, State, Zip Code) all, MD 20622	
Pages 1 ar		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	removal from State		sposition (Name of rematory or other place ourney Cre		Date 1/2010		- City or Town, State ine, MD	
permit. Pages 1 Department of I Important: If ite any injury or ot		21. Signature of Funeral Service Licens		rshall	22 Name and Addre	ess of Facility		Servi	ces MD 21203	
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the cause on each line. Due to (or as a co	my op	enter the mode of dyi	ing, such as cardi		rrest,	Approximate Interval Between Onset and Death	
ficate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Out to (or as a consequence of): Out to (or as a consequence of):								
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as it	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 Live birth 2 4 Pregnant at tin 9 Unknown	Fetal death	3 Ectopic pregnant 5 Other (specify)	су			ate of delivery onth Day Ye ar	
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	Completed	Respiratory Far Purtmed Viscos	lure vero	theater	Deponde	er s	24a. Was		Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	le f
Physician: The this certificate all director, pag	To Be	25. Was case referred to medical	dospital:			26. Place of D	eath <i>(Check only o</i> Home 5 Resid		ther (Specify)	
77 D D	Certification:	27. Manner of Death 1	28a. Date of Injury (Month, Day, YA AUgust 12, 2 28e. Place of Injury building, etc. (009 UNKA	y Wo	⊒Yes 2XNo	28f Location /	cycle A	+ 1	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	Medical Cer	29a. Certifier 1 € Certifying Phy	sician: To the best of n	Street ny knowledge, d camination and/o	eath occurred at the	time, date and pla	ice, and due to the	cause(s) and n	Waldoff, mo 2060	2
To the within To the complex	Me	29b. Signature and title of certifier	Our	and	29c. Licen	se number	2_		ed (Month, Day, Year)	,

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 18 Georgia G. Wilson 2010 10:26 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 981 North Hill Road Baltimore 5. Social Security Numbe 7. Age (In vrs. last birthday) If Unde 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** Month: Hours Min 1 □ M 2√ F 140016 Pay 9733 215-28-3719 76 NC. **Director** Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No n/a Baltimore MD 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? Hygiene. other than "natural", or items 23a or ent, the Medical Examiner must be r Funeral 981 North Hill Road 21218 USA . Page 1 and 2 should be filed within 72 hours after death wrent of Health and Mental Hygiene.
tant. If item 27 is marked other than "natural", or items luny or other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 X Divorced Specify: African-American Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Health Care Bon Secours Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Roland Wilson Sallie Strong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia P. Williams/ Daughter 12231 Bare Brush Path, Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place, King Manorial Park 1X Burial 2 Cremation 3 Removal from State 9-24-2010 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Immediate Cause (Final disease or condition Onset and Death Physician. 100 Medical resulting in death) u to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events.) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician dbe detached for use as the bunal Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 No 21 1 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director. Be 26. Place of Death (Check only one) Other: 1 Tes 2 DIO မ ER/Outpatient 3 DOA 4 ☐ Nursing Home 5. Residence 6 ☐ Other (Specify) 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of Certificate: 28c. Injury at After 28d. Describe how injury occurred work? atural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director; 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and ad

31. Date filed (Month, Day, Year)

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back

ress of person who completed cause of death (Item 23a) (Type, Print)

32. Registr

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ptonbar Charles Aubrey Williams 2000 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHIZENS NUCSING Hame DG ance HUNC If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year)
NOV 4, 1911 Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Pennsylvania Director 186-10-9116 98 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 😾 No Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2103 Williams Drive 21078 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3 XWidowed 4 ☐ Divorced Black Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Minister Religion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Ellen Evans Charles Lewis Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita M. Williams / Daughter 3196 Gainer Drive, Powder Springs, GA 30127 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gdn . 9-24-10 Aberdeen, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final 1317 Cokesbury Rd., Abingdon, Approximate Interval Between Immediate Cause (Final disease or condition ely dralion Physician/ Medical resulting in death) Due to (or as a cons Examiner 64165 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a con The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has or Attending Physician: Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🖫 No 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) ō 28c. Injury at work?
1 Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After t
completed filled in by the funera Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D32609

State Registrar 31. Date filed (Month, Day,

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favre De Grace MD 21678

30. Name and address of person who completed cause of death (Item 23a) (Type, Brint)

Milham rus 110c 1

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ Month RI 121 SOPTEMBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death BALTIMOR SILCHRIST CUNT If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 X M 2 - F Aug 16, Yar 1919 Maryland 217-26-5840 91 **Director** Usual Residence of Decedent 10a. State than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1055 W. Joppa Road #201 21204 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 24 Yes 2 No Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 41-46 Specify: white Completed 3 XWidowed 4 Divorced Year or Dates. un 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 77 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 salesperson Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gertrude Elizabeth Schmidt Carl E. Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 728 Camberley Circle #A2 Towson, MD Louise Gibson/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Signature of Funeral Sept e Licensee State Anatomy Board 655 W. Baltimore Street ector MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Deat Immediate Cause (Final Physician/ MOTASTATIC LUNG disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Gequentiary hat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 - Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death sate has been signed by the a page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by ULCERATIVE COLITIS 1 Yes 2 No 3 Probably 4 Unknown Completed CHRONIC OBSTRUCTIVE PULMONARY DISPASE Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? ARTORY DISCASE eral Director: After this certificate filled in by the funeral director, pag CORONARY 2 🗆 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) HOSPICE examiner? Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direct Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

State Registrar

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ark Walters		1- For State Of Maryland / Department of He			2010 2988
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
″~dical Exami		Mark Walters		Month September	3, 2010 Year 1749 hrs
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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. ten 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f homeless	Zip Code	unk 10	g. Citizen of What Country? USA
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21215-0036 July be filed within 72 hours afte Montal Hygiene. marked other than "natural", ic event, the Medical Examiner		17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M	
121 be fi ental I went,	å	Clyde Wesley Walters	Barbara	Eudori	a Hockenberry
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	리	19a. Informant's Name/Relationship (Type, Print) Clinton Walters-brother O.C.M.E. 19b. Mailing Add 4327 Le	ela Ave. NE R	oanoke,	ber, City or Town, State, Zip Code) Virginia 24019
i, MD and 2 sho ealth and tem 27 is		20a. Method of Disposition 20b. Place of Disposition		Date	20c. Location - City or Town, State
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/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Death
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Box 68760, e death certificate be the attending physicied for use as the burned for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the 2. Fetal december 2. Setal december 2. Setal december 2. Fetal december 2. Setal december 2.	eath 3 Ectopic pregna	ancy	23d. Date of delivery Month Day Year
X 6 tth cer ttendi	sicia	A Non O No O University	(Specify)		
. BC he des y the s	ڳر ک	Part II. Other significant conditions contributing to death but not resulting in the under	lving cause given in Part I	23e. Did to	bacco use contribute to the cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	þ			1 Yes	2 No 3 Probably 4 Unknown
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n of ding Ph	on:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury (Month, Day,Year)	1 Yes 2 X No		
Sior Attence r death ector: by the	icati	2 Accident Investigation 28e Place of Injury - 4t home, farm street, fa	rs	unkno	Street and Number or Rural Route Number, City
Divi	Certification	3 Suicide 6 Could not be determined (Specify) Street	,,	or Town, S Madisor	tate) Guilford Ave. & n St. Balto, Md.
Divis Hospital or A 24 hours after Funeral Dire		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a	at the time, date and place, and	d due to the caus	e(s) and manner as stated.
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.		at the time, date	
	Σ	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year) September 4, 2010
		1aunul	O.C.M.E.		- Coptember 4, 2010
i		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn S	treet, Baltimore, MD 21	1201	
_s	tate				
Regis					

10-06708 Leonard Ward Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2010 29885 State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month **Medical Examiner** 1548 hrs Leonard Ward September 5, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 6. Sex 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** ForeignWashington Min. Months Days Hours Director 578-52-8909 1X M 2 F 70 Yrs Country) Dec 12. 1939 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Examiner must be notified at once. 1 Yes 2 No Silver Spring Montgomery death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2901 Shepperton Terrace 20901 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? 1 Never Married Married it. Pages I and 2 should be filed within 72 hours after dea ment of Health and Montall Hygiene. Trant: If item 27 is marked other than "natural", or item or other traumatic avens. 1X Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: black ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 butcher food industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Ward Eulee Thompson ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfreida Montgomery/sister 84 Montgomery Road Lyman, SC 29365 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Pages
Department of
Important: I Donation 5 X Other Specify: in state 21. Signature of Funeral Service Licensee Ronal of S 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician ilure. List only one cause on each line. Between Onset and /Medical Complications of chronic alcohol use Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last icate has been signed by the attending physician and page 2 should be detached for use as the burial - transi Physician/Medical XUNPENDED AMENDED 733, PII, 27, per ME , g908 10/4/10 TT Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Diabetes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy this certificate has performed' 1 🗸 Yes ✓ Yes 2 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other ဥ 1 V Yes 2 No 28a. Date of Injury (Month, Day,Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No hours after death. Fo the Funeral Director: the 2 Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 241 Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 6, 2010 30. Name and address of persor e of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Dorothy A. Wilhelm PM M September 2010 4:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Towson Baltimore 8. Date of Birth (Month, Day, Year) Aug 6, 1941 Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Maryland 219-38-4753 69 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or lother traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6225 York Road N112 21212 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces 1 X Never Married 2 Married þ 1 Yes 2 XNo 1 ☐ Yes 2 🛣 No Specify: Specify: white 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk animal caretaker Baltimore Zoc Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Wilhelm Mary Elizabeth Geelhaar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Wilhelm/brother 322 1/2 Townsend Road Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cometery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ▼ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Renald S Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final m Interval Between Onset and Death Physician/ Luna Cancer disease or condition Medical resulting in death) Due to (or all a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 👿 Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No has le 2 this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 📉 No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred

Box 68760 P.O. Records, within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital

Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ah, com 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

work?
1 Yes

2 🗌 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N. Charles of 31. Date filed (Month, Day, Year) State

Medical

1 X Natural

Accident

3 Suicide 4 Homicide

29a. Certifier

5 Pending

Investigation

determined

6 Could not be

4105

Registrar

injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

10-06658 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible amend #State of Maryland & Department Health Alla Mental Hyder 606/10 JH Kenneth Lynn Wormald, Jr. 1- For State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3 Time of Death Physician/ Month Day September 3, 2010 Madical Examiner 1732 hrs Kenneth Lynn Wormald Jr 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Carroll Mount Airy If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 1 6. Sex 7. Age (in yrs. last birthday) **Funeral** Months oreian Davs Hours Director 283-38-0244 1XM 2 F 69 Country) Ohio July 16, 1941 Usual Residence of Decedent 10b County 10c. City. Town or Location 10d Inside City Limits 1 Yes 2 No MD Carrol1 Mount Airy Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 Hoff Court 21771 USA Funeral 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1X Yes If Yes, Give Year 3 Widowed 4 Divorced 1 Yes 2 No specify: Specify: white ₫ 16a. Decedent's Usual Dccupation (Give kind of work done unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed unkduring most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Computers 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) -unk Be and Mental Charles MArshall Wormald Dorothy Marie Reese ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MacKenzie A. Kantruss/attorney 604 E. Ridgeville Blvd Mt. Airy, MD 21771 Baltimore, MD it: If item 27 i of Health 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Page:
Department o
Important:
injury or oth Donation 5 X Other Specify: 21. Signature of Funeral Service Licensee Ronald S Wa 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director Approximate Interval Physician art I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Between Onset and /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and AMENDED #1as notated, perME, G908, 10/21/2010, WS 23a, 27, per ME g908 10/8/10 TT sician/Medical attending physician a for use as the burial -X UNPENDED The law requires that the death certificate be Box 68760 JE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed been should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has performed? death? page certificate Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗹 Other Scene ER/Outpatient 3 DDA this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1X Natural 1 Yes 2 No the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day Year) O.C.M.E. September 4, 2010 Mome Muld 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 32 Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death September Physician/ Year 2010 12:45 A M Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** t-lizabeth Cent Bultimore N/A WYSIM 6. Sex 1 X M 2 D F If Unde 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. Funeral 62762/1925 Maryland 85 Director 212 20 4403 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director Baltimore Arbutus or 28a-f Maryland 1 🗌 Yes 2 🏻 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21227 U.S.A. 1233 Stevens Avenue 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc 0 Completed by 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates. Yes 2 No Specify Specify: "natural", 3 Widowed 4 Divorced White WW TT permit. Page 1 and 2 should be filled within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 9th College (1-4 or 5+) Notre Dame College Plumber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Weldon Wareheim Annie Dahl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Wareheim-Boyer 7804 Halehaven Court Severn, Maryland 21144 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland 09/18/2010 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Gonce Funeral Service, P.A. 21. Signature of Funeral Service License 22. Name and Address of Facility 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final Physiciani neumonia disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) accidents bra Vascu 191 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be up thours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: f yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Month Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗖 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform To the Funeral Director; After this certificate I completed filled in by the funeral director, page 2 🗆 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 🔲 Yes 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital or within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or inventioning in any applications of the course of examiners and the course of examination and/or inventioning in any applications. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) eptember 17, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2122 MO 320 euson venu

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Items 23aPt1,11,25,27,28a-I per me,g907,09/23/2010dhb
Registrar Certificate of Death Reg. No Reg. No.? I. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Wolff 01:30 Bettv Estelle 09 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore Riverview Nursing Center If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min 1 - M 2 X F Months Days Hours *ᲥᲧ*ᲧᲧᲧᲧ MD Director 83 215-22-3414 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Middle River Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or Funeral U.S.A. 21220 529 Compass Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 🗆 Widowed 4 🕱 Divorced White and Mental Hygiene.
is marked other than "natu aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Kev Punch Operator US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be fi Department of Heatth and Menta Important: If item 27 is marked any injury or other traumatic ev once. Vogt Arthur Marv Elbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 529 Compass Road, Middle River, MD 21220 Barbara Opitz, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 9/14/10 4 Donation 5 Other (Specify) Parkwood Cemetery Baltimore, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. letandua & Blan 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ch line Interval Between Onset and Death shock, or heart failure. List only one cause on ea Immediate Cause (Final neum=nig Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examine hrunic Obstru equentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dura Records, 1 Yes 2 No 3 Probably 4 Unknown certificate has been Hip Fracture 24b. Were autopsy findings available prior to completion of cause of 24a. Was an , page 2 autopsy Dementia Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? of Vital funeral director. 26. Place of Death (Check only one) Be Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) After this

Certificate: To

Manner of Death 2 Accident 5 Pending Investigation 6 Could not be Suicide Homicide determined

31. Date filed (Month, Day, Year)

SEP 2 3 2010

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of (Month, E 2010

28c. Injury at Unknown 1 \(\text{Yes} \) 2 X No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Nursing Home

28d. Describe how injury occurred Multiple falls

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Eastern Bullevard Essex, MD

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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Balt more MI

State Registrar

or Attending

Hospital hours Funeral

death

24

within 2 the

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leted filled in by

Medical

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / E	Department of Heal Certificate of Deat			2011	29890		
	Physicia	ın/	1. Decedent's Name (First, Middle, Last) ERVIN WILDER	Oertineate or Deat	2. Dat	Reg. Note of Death		3. Time of Death		
-	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Locat			21 2010 c. County of Deat	7:30 P M		
d			MERCY_HOSPITAL	BALT IMORE			N,			
I	Funeral Director		210-12-3214	nday) If Under 1 Year If Under 1 Year Hours.		e of Birth onth, Day, Year) 07 / 1924	9. Birt Coa	hplace (State or Foreign untry) MD		
	nd now	ř	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits		
	Marylar 28a-f sl	Funeral Director	MD BALTIMORE	BALTIMORE				1 ☐ Yes 2XX No		
	with the s 23a or ust be r	eral [10e. Street and Number 1 BABETTE COURT	10f. Zip Code 212	208	10g. C	Citizen of What Co	•		
980	permit. Page 1 and 2 should be filed within 72 hours afte death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic If Yes, specify Cuban, Men 1 Yes 2 X No Spe	xican, Puerto Rican, e	or No- etc.)	14. Race - Amer Black, White Specify:			
Maryland 21215-0036	vithin 72 hou jiene. er than "natu the Medical	Completed by	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) ACCOUNTANT	most of working	16b.	Kind of Business	·		
land;	d be filed v Mental Hyg arked othe	To Be	17. Father's Name (First, Middle, Last) VICTOR WILDER		Mother's Name (First,	Middle, Maider	_ '	,		
Mary	2 should Ith and M 27 is ma ' trauma			Mailing Address (Street and Nu	umber or Rural Route					
re,	1 and of Hea fitem		20a. Method of Disposition 20b. Place of	Disposition (Name of y, crematory or other place)	Date		Location - City or			
altimore,	. Page ment tant: It		1 E Dunai 2 - Oremation o - Henovalnomotate 1	ILOH CEM.	9/22/201		TIMORE,			
Ball	Depart Impor any in		21. Signature of Funeral Service Licensee	22. Name and Address of F. 8900 REISTERS						
	hysician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	-	h as cardiac or respir	atory arrest,		Approximate Interval Between Onset and Death		
	Examiner		Due to (or as a consequence of	n: o ke_				3 weeks		
	rted d ansit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	n. Certiorascular	Dixione			15 years		
09	ate be executed ohysician and the burial-transit	dical Ex	that initiated events resulting in death) Last Due to (or as a consequence of d.	f):	-					
876	ificate l ig phys as the	Med	IF FEMALE:			- 1				
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		_	23d. Date of deli Month	very Day Year		
s, P.O	es that the dea signed by the a 1 be detached f	by	Part II. Other significant conditions contributing to death but not resulting in	Part I. 23		cco use contribute to the cause of death?				
cords	aw require as been si 2 should t	Completed			24	a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of		
Re	cate has	Соп			1 [performed? Yes 2	death?	2 🗆 No		
ital	Physician: T this certifica	Be c	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	Other: _	Death (Check only or					
of V	ding Phys th. After this funeral di	ate: To	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) in	me of jury 28c. Injury at work?		Residence scribe how inju		5)		
Division of Vital Records,	I or Attend after death Director: /	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)					n (Street and Number or Rural Route Number, own, State)		
	To the Hospital or within 24 hours afte To the Funeral Dir completed filled in	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or only one) Certifying Nurse Practioner: To the best of my knowle	investigation, in my opinion, deat	th occurred at the time	, date and place	e, and due to the c	ause(s) and manner stated.		
	To th withir To th comp	-	29b. Signature and title of certifier	29c. License numb	per	29d. Da	ate signed (Month,	Day, Year)		
			by the mo	73867	5	ser!	rember	22 2010		
			30. Name and address of person who completed cause of death (Item 23a) (Ty LOEL MESHULAM 301 ST (AUL (L S		guin one	MO	21202			
	Stat	e	31. Date file from Day, Year of the Secretary's Signature of the Secretary Secretary Secretary Secretary Secretary Secretary Secretary Secretary Secretary Secretary Secretary Secretary Secretary Secretary Secretary Secre		, =, -,	* */				
	Registra	ir	Laure B. Da	Ver						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2989 Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2:15 P M **Physician** Adams Dis 2010 6 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** Chas hasles Country Nursings la louta Konow If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month), Day, Year) 10/6/1915 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Months Days Min. 1 □ M 2/EXF 513-03-6677 94 0klahoma Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location or 28a-f show notified at 1 ☐ Yes 2 ☑ No Director Prince George's Ft. Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be a 20744 USA 13225 L'Enfant Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 213 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify Specify: White 2 3€ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than Iry or other traumatic event, the M Homemaker In Home years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry C. Williams Francis Ε. Montague 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lois Ann Smith / Daughter 13225 L'Enfant Drive Ft. Washington, MD 20744 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/08/2010 | Edgewater, Maryland Kalas Crematory 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature of Funeral Service Licensee Kels 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or an a consequence of): nillation Examiner NOW V Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examine law requires that the death certificate be executed 510h sician and burial-tran consequence of) physician a Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes ed by the 9☐Unknown 9 Unknown signed by t d be detach conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant Completed by FOU 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an this certificate has page 2 autopsy performed? Yes 2 No The Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Certification: 1 Natural 2 Accident To the Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. hours after death.
uneral Director: /
ly filled in by the fi 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 108 10 30. Name and addrest of person who completed cause of death (Item 23a) (Type, Print)
JOSJIN VA 2happilly, 2007 Tidewater Colony Dome 17, Annapolis,

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

amend #6 Per State of Maryland / Department of Health and Mental Hygiene 0 | 0 State
Registrar Amend#26.PerPhys.PGC9-10-10cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 28. 2010 Mamie Anderson 4:30 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7206 Abbington Drive Oxon Hill Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Yea Sept. 3, Social Security Number 1 1 2 XX **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign South Carolina Director 578-20-1108 89 Sept. Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20020 United States 3955 R Street SE 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ⚠ No If Yes, Give "natural", or iten edical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc <u>გ</u> 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Clerk Government Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lawrence Smith Edna Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7206 Abbington Drive Oxon Hill, Md. Gregory Ford/ Cousin Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Sept. 8, 1

Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Suitland, Maryland Lincoln 21. Signature of Funeral Service Licens 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019 23a. Part Sater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 10~77HS (Tiysiciai) disease or condition resulting in death) Medical Examiner Securation list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? MELLITUS 1 Yes 2 No 3 Probably 4 Unknown Completed PURTENSION, HEART BLOCK PACETAKER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 24 hours after death.

Funeral Director: After this certificate Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be examiner? Other: 4 \(\triangle \) Nursing Home \(\frac{1}{2} \) Residence (6) \(\frac{1}{2} \) Other (Specify) \(\frac{1}{2} \) Residence (6) Cousin's 1 Tes 2 No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 Tes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Degedent's Name (First, Middle, Last) 2 Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number Location of Death Examiner TIMOr 8. Date of Birth Funeral 9. Birthplace (State or Foreign Months (Month, Day, 2/24/1 New York 060-34-9903 **Director** 67 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2 🛣 No MD Chestertown Kent 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21620 USA 9784 Swan Court 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: "natural", 3 Widowed 4 Divorced Specify: White Year or Dates permit. Page 1 and 2 should be filled within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical! 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Beatrice Florence Arnholt George Stretton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9784 Swan Court Chestertown, Maryland 21620 Mac Burns - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 09/13/2010 Chester, Maryland Chesapeake Cremation 21. Signature of Funeral Service License 22. Name and Address of Facility Fellows, Helfenbein & Newnam 130 Speer Road Chestertown, Maryland 21620 23a. Part 1. Enter the disease, or com to flions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only Orset and Deat Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 2 X No Other: ည npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident injury 5 Pending work? within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 25 ss of person who completed cause of death (Item 23a) (Type, Print) 1215

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 01, 2010 JoAnn M. Blocher 6:54 P M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex (Month, Day, Year) Oril 16,1932 Pennsylvania Months Days Hours 1 □ M 2 🔀 F

10d. Inside City Limits

USA

14. Race - American Indian, Black, White, etc.

16b. Kind of Business Industry

Beauty Salon

White

1 Yes 2X No

Social Security Number **Funeral** 78 199-24-3973 **Director** April Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Me lical Examiner must be notified at Director Arnold MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 543 Norton Lane 21012 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Yes 2 X No Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner/ Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Columbia Russo Ralph DeCarlucci, Sr. 19a. Informant's Name/Relationship (Type, Print) John Blocher/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 07, 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Sept. (Lakemont Memorial 21. Signature of Funeral Service Lice 495 Ritchie Hwy, Part 1. Enter the disease, of shock, or heart failure. List Unmediate Cause (Final disease or condition resulting in death) Physician/ Decom persuted Medical Due to (or as a consequence of): Examiner Alcoholic Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit The law requires that the death certificate be executed bolic muta that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Puna Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 1 Yes 2 L 9 Unknown 2 No signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, should Completed Yes **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: Natural 5 Pending work? n 24 hours after death. e Funeral Director: Aft bleted filled in by the fur 2 | No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier npleted

State Registrar

Physician/

Medical

Examiner

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 543 Norton Lane Arnold, MD 21012 Davidsonville, MD Name and Address of Facility rranco & Sons, P.A. Severna Park Funeral Home 55 Ritchie Hwy, Severna Park, MD 21146 of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Defining Physician. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 4007842 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 800 32. Redistrar's Signature State Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:50ам Debra J. Berger September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda 5801 Nicholson Lane. 9. Birthplace (State or Foreign Country) New York Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛛 F Days Hours (Month, Day, Year, June 27 1 **Director** 72 091-30-0578 June. Usual Residence of Decedent within 72 hours after death with the Maryland items 23a or 28a-f sho her must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗓 No Maryland N. Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral #1902 5801 Nicholson Lane. 20852 n "natural", or item Iedical Examiner n 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates permit. Page I and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Non-Profit Organization 5+ Founder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anne Wilkins Saul D. Herman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul S. Berger - Spouse 5801 Nicholson Lane. #1902. N. Bethesda. MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State Mt. Lebanon Cemetery 109/02/2010 | Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M01024 22. Name and Address of Facility Hines-Rinaldi Funeral Home, ৴৻ 11800 New Hampshire Ave., Silver Spring. 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer nly one cause on each line Onset and Death Immediate Cause (Final Physician/ Progressive Supranuclear Palsy disease or condition resulting in death) ears Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? after death.

Director: After this certificate ! 2 X N 1 🗌 Yes 2 No Yes completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 A Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗓 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Norse Fractioner: To the best of my knowledge of det the time 29b. Signature and title of certifier SomhA BAII MD D53317 September 01, 2010

15

State

Registrar

Suite 213, Gaithersburg, Maryland 20877

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 16220 Frederick Road,

32. egistrar's Signature

Resur

Joseph Ball,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Vear **Physician** June Elizabeth Biser 09 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Garrett 0akland Dennett Road Manor Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1922 Min. 1 □ M 2 🛣 F Months Days Hours **Director** 88 MD 218-10-9862 Usual Residence of Decedent 10d. Inside City Limits show 10a. State 10c. City, Town or Location 10b. County traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director 0akland 28a-f MD Garrett 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 'natural", or items 23a or 21550 1113 Mary Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+ permit. Pages 1 and 2 should be filed wit Department of Health and Mential Hygien. Important: If item 27 is marked other the any injury or other traumatic event. Business Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary M. Whitlatch Asa M. Queer ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 Maypole Lane, Oakland, MD 21550 Donald Mason-son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/15/2010 Cumberland Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licenses David A. Burdock Funeral Home P.A. 21 N. 2nd St, Oakland, MD 21550 Approximate Interval Between Onset and Death 23a. Part/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cevenru Physician week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 1 ☐ Yes 2 funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 □ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death i Welt Acres Dr Ocalelan Danie au 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29897 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Leo John Bradley September 14 2010 9:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 18918 Bradley St. Barton Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Year) 1929 Days Hours Min 212-24-2102 1 XM 2 □ F 80 Months Marvland Director Yrs. Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Allegany Barton 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18918 Bradley St. 21521 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: white Completed 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Tire Manufacturer Elementary/Seconday (0-12) College (1-4 or 5+) Tire Builder Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame)
Marcella Footen permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic ew ည John Bradley 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 323, Midland, Maryland 21542 Nancy Bradley/ daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Rest Lawn Mem. Garden 09/18/2010 Cumberland Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p for use as t IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a d be detached f 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 3 Probably 4 ☐ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N page 1 Yes 2 No 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completed filled in by the fun **1**∰ Natural injury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Aurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29c. License number D0033280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Sunil Gupta, 625 Kent Ave, Cumberland, MD

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

Box 68760

P.O.

10-07037	
Marc Burns	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rc Burns	State of Maryland / Departme	ent of Health and Mental H te of Death	ygiene 2010	29898
Physician	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year	3. Time of Death
edical Examine	Hale william buins		September 12, 2010	2253 hrs
	Name (if not institution, give street and number) Western Maryland Health System	4b. City, Town, or Location of Death Cumberland	4c. County of Dear	ın
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birth		- 1	
Director	216-08-9612 1 X M 2□F 25	Yrs. Months Days Hours Min		ountry) MD
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of the county	r Location		10d. Inside City Limits
	MD Garrett Oaklan	nd		1 Yes 2 No
the Marylanda or 28a-f stified at one	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	untry?
th the last or sotified last of last or last of last or last o	2520 Old Crellin Road	21550	United Stat	
Ore, MD 21215-0036 se 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho ther traumatic event, the Medical Examiner must be notified at once. To Be Completed by Finneral Director	11. Marital Status 1 X Never Married 2 Married Amed Forces?	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 		rican Indian, Black,
ifter de	1 Yes 2 No 3 Widowed 4 Divorced of Dates:	1 Yes 2 No specify:	Specify: W	hite
natural" xamine	45 Book of Education (Considerable billion to advance to take the B	ecedent's Usual Occupation (Give kind of vuring most of working life. DO NOT use reti	work done 16b. Kind of Business	
215-0036 be filed within 72 hours after that Hygiene, rked other than "natural", ent, the Medical Examine. Be Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	11. 17. Father's Name (First, Middle, Last)	Laborer 18.Mother's Name	(First, Middle, Maiden Surname)	truction
21218 uld be fill Mental H marked c event, f	Mark Whitacre		etta Burns	
D 21 should and Me 7 is ma		Mailing Address (Street and Number or F		
ore, MD ss 1 and 2 shou of Health and 1 If item 27 is refer traumatic	20a. Method of Disposition 20b. Place of	520 Old Crellin Road Disposition (Name of cemetery,	Date 20c. Location - City o	
nores 1 ages 1 at: If i	Darial 2 Clemation 5 Removal non-state	ry or other place) ark Cemetery 9/1	.7/2010 Deer Parl	z MD
Baltimore, permit. Pages I and Department of Heal Important: If iten injury or other tra	4 Donation 5 Other Specify: Peer Pa 21. Signature of Funeral Service Licensee	22. Name and Address of Facility David A. Burdock F		x, rib
	23g. Part I. Enter the disease, or complications that caused the death. Do not			Approximate Interval
Physician /Medical	failure. List only one cause on each line.	enter the mode of dying, such as cardiac o	respiratory arrest, shock, or heart	Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):			
di	Sequentially list conditions, b. Due to (or as a consequence of):		<u>.</u>	
ted nasit Examine	cause. Enter Underlying Cause (Disease or injury that initiated			
uted nd ransit	events resulting in death) Last Due to (or as a consequence of):			
Records, P.O. Box 68760, The law requires that the death certificate be excouted cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit completed by Physician/Medical Ex.	UNPENDED AMENDED			
68760 ertificate t ding physi e as the bu	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth	Fetal death 3 Ectopic pregna	23d. Date of deliver	ry Day Year
30x 6876 death certificate e attending phy I for use as the b	4 Pregnant at time of death 5	Other (Specify)	INIO/INI	Day Teal
by the a sched fo	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I	23e. Did tobacco use contribute to	the cause of death?
P.O. ss that the gred by e detach		in the underlying cause given in Fait i.	1 Yes 2 ✓ No 3 Pro	
Records, P.O. The law requires that ficate has been signed by agge 2 should be detail.				utopsy findings available completion of cause of
eco he law ate has age 2 sl			performed? death?	
tal Recition: The certificate rector, page	25. Was case referred to medical	26.Place of Death (Check		
of Vital ng Physician: After this certis meral director n: To Be	1 ✓ Yes 2 No Inpatient 2 ER/Out		g Home 5 Residence 6 Othe	er:
ision of Vital I Attending Physician: T death. Tector: After this certify by the funeral director, by the funeral control of Be (cation: To B	27. Manner of Death 28a. Date of Injury 28b. Ti 1	me of Injury 28c. Injury at Work? hrs 1 Yes 2 V No	28d. Describe how injury occurred Passenger in auto collision	
Division tal or Attendiums after death.	2 V Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, fare	m, street, factory, office building, etc.	28f. Location (Street and Number or R	ural Route Number, City
Division o Hospital or Attending 24 hours after death. Funeral Director: After filled in by the fune al Certification:	4 Homicide determined (Specify) Interstate/Expres	s	or Town, State) I 68 @ mile marker 54, Cumberlar	nd , MD
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	29er Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death one) 2 ✓ Medical Examiner: On the basis of examination and/or inv			
T S S S	and manner stated. 20b. Sibnature and title of certifier	29c. License number	29d. Date signed (Mo	onth, Day, Year)
	(Landorleum)	O.C.M.E.	September 13, 2	2010
3	30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111	Penn Street, Baltimore, MD 212	01	
State	31. Date filed (Month, Day, Year) 22. Registrar's Signature	The state of the s		
Registra		we		· · · · · ·
HMH 17 Rev 1/2001	OCME ORIG	GINAL		

DHMH 17 Rev 1/2001 OCME 2006

OCME

State Registrar 7801 OLD BRANCH AVENUE # 101 CLINTON, MARYLAND 21045

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHOSROW DAVACHI M.D.

August 31 Pay 2010 Pear Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Montgomery Suburban Hospital Bethesda . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Months Days Hours Feb. 26, 1939 1 □ M 2 😾 F 579-70-4328 71 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director D.C Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20012 United States 815 Juniper Street, N.W., #302 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc ρ 1 X Never Married 2 - Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exan once. If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Records Manager Legal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mildred Sumner James Alexander Wharton Brereton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7605 Clare Court Laurel, Maryland 20/0/ Maxine P. Gill -Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metropolitan Crematory 9/6/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Monald 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physiciani Arteriosclerotic Heart Disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): signed by the attending physician and defached for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical TOD: 2024 Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Bath 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li Fetal use... Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 Yes 2 XNo 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 8/31/10 <u>ک</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🚨 No this certificate JUAN BREKETUN __ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Division of Vital Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 1 ☐ Inpatient 2 🕅 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work' Accident Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

1. Decedent's Name (First, Middle, Last)

Brereton

H.A.

Physician/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

20:24

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Xyes 2 □ No

Georgetown, Guyana

Black

Maryland 20705

Approximate Interval Between Onset and Death

Day

1 Tyes 2 No

2010

Year

State Registrar

31. Date filed (Month, Day, Year SEP 1 0 2010

32. Regist ar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brendan J. Carmody, M.D. SH 8600 Old Georgetown Road Bethesda, Maryland 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Daniel Albert Brunner Physician/ September Day 12,2010 11:15 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Smithsburg 11926 Haven Hill Dr. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 € M 2 □ F Min. Dec. 24, 1926 Months Days Hours Maryland 212-24-5760 83 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Smithsburg 1 ☐ Yes 2 첩 No Md. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21783 U.S.A 11926 Haven Hill Dr. 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Specify. "natural", 3 ☑ Widowed 4 □ Divorced White Completed 50-55 Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Railroad Track Repairman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Letha I. Wolfe Wilbur L. Brunner Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Merton Court Goose Creek S.C. 29445 Brenda Jackson (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State $Sept^{Date}$. 14, 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Smithsburg Crematory 4 Donation 5 Other (Specify) 2010 Smithsburg,Md. Signature of Funeral Service Licenses 22. Name and Address of Facility 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home WIS Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ كاسمعرادا resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to or as a consuluence of cause. Enter Underlying Cause (Disease or iinjury that initiated events Exam Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Medical Box 68760 E FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe this certificate 1 🗌 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 JNO မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director; After thi
completed filled in by the funeral I 27. Manner o⊁Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the bysis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 3 [Certifying Nurse Practions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signati re and title of certifier 30. m and address person who completed cause of death (Item 23a) (Type, Print) JH-6+1

DHIVII HOV 1, 2006

State Registrar 31. Date filed (Moi

egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2010 6:20 PMM Florence Evelyn Bildstein Sept 6 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot Genesis HealthCare

6. Social Security Number 6. Sex The Pines Easton If Under 1 Year Birthplace (State or Foreign Country) 7^{Year)}1921 **Funeral** Hours 1 M 2X DX Months Days Min. 213-18-4142 89 Maryland **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shany Injury or other traumatic event, the Medical Examinat must be notified. Funeral Director MD Talbot 1 X Yes 2 No Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 Dutchman's Lane 21601 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. em 27 Is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Completed by Specify White Specify: 3 ₩ Widowed 4 Divorced Yeer or Dates: Bildstein 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Otto Steenken, Emma Worm 2 Florence 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Stevenson/Daughter 1205 Jefferson Ave., St. Michaels, MD 21663 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Junior Order Cemetery 09/09/10 Preston, Maryland 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service License Michael 7-216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner was Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed newsderogo 112225 and burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Day 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate l 2 No spital or Attending Physician: Ti hours after death, ineral Director: After this certificate y filled in by the funeral director, pa 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check onl. one) 1 Yes 2 No Hospital: Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

ROWLEY

8 2010

MICHAEL

31. Date filed (Month, Day, Year)

MA

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 2010 **Physician** RAYMOND FRANK CARMINE 7, September 3:26A^M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 118 Front Street Queen Annes Crumpton 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthdav) If Under 1 Year | If Under 24 Hrs. **Funeral** Min. Months Days Hours 1 **3** M 2 □ F Director <u>216-36-9249</u> 10/13/1938 Baltimare City, MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show MYes 2 No Director MD Queen Annes Crumpton 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 118 Front Street 21628 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1. Tyes 2 No Iryes, Give Year or Dates: 59 – 62 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 😥 No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Automobile Elementary/Secondary (0-12) College (1-4or 5+) Benefits Administrator Manufacturer 12 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond L. Carmine Minnie Marie Reinhardt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 any Injury or other trong once. 27 Paul K. Morgan, Jr./Executor Ρ. O. Box 67, Crumpton, MD 21628-0067 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Natural 2 ☐ Cremation 3 ☐ Removal from State St. Pauls Cemetery 9/9/2010 Chestertown, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility DANIELS & HUTCHISON FUNERAL HOME LLC 212 N. Broad Street, Middletown, DE Approximate and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate and the cause on each line. 23a. Part 1. Enter the disease, shock, or heart failure. List Interval Death Onset and Death Immediate Cause (Final Physician An weatie CARCIZIONER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-trar and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical the attending pl IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy ģ in the past 12 months? Month Day Year 5 Other (specify) I ☐Yes 2 ☐ No the 9 Unknown icate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 @ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? V po / Hyroslis 24a. Was an autopsy performe certificate fral Fibrillation 1 ☐Yes 2 ☐ No 1+3lang OF 1 □Yes 2 🙀 No Hospital or Attending Physician; 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide

completely the within To the

State

Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD Jr 32. Regist

and manner stated.

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

September 8, 2010

223 High Street, Chestertown, MD 21620

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Division of Vital Records, P.O. Box 68/60,	Hospitel or Attending Physicien: The law requires that the death certificate be executed	4 nours arier deain. Funeral Director: After this certificate has been signed by the attending physicien and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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		•	State Registrar		Ce	rtificate of L	Death	2. Date of Dea	eg. No.		3. Time of Death
	Physicia /Medic		Decedent's Name (First, Middle, La MARGARET		RANDALL			SEPTEM		4 2010	
	Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or	Location of Death		4c. C	County of Death	1
**			WASHINGTON ADVE 5. Social Security Number 6.		L rs. last birthday)		PARK If Under 24 Hrs.	8. Date of Birth		NTGOMER 9. Birth	Y nplace (State or Foreign untry)
	Funeral Director			1□M 2X F 8.5	Yrs.	Months Days	Hours Min.	(Month, Day	, Year)		Intry) HINGTON, DC
	ס		Usual Residence of Decedent					AUGUSI		723 ***	10d. Inside City Limits
	ehow	ř	10a. State 10b. County	GEORGE 'S	City, Town or L HYATTS						1 Yes 2 No
	he M.	ectc	MD PRINCE 10e. Street and Number	GEORGE 5	піАІІЗ	10f. Zip Code			Og. Citiz	en of What Co	untry?
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Ž	Ment Market Market	P	PIETRO PETRON				PAULINE			Town State 7	To Codo)
Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relationship MARGARET RAY/N			ing Address (Street 9 CLOVER 1					
กั	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene at the first is marked other than "naturet, or iteme 23a or 28a-1 ehow other traumatic event, the Modical Exemitive is use be notified at		20a. Method of Disposition		b. Place of Disp	osition (Name of ematory or other place		Date		cation - City or	
Dalling	permit. Pages 1 an Department of Heal Importent: if item 2 eny injury or other once.		1 Nation 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec			LL CEMETE		/2010	SUTT	LAND, MA	RYLAND
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	in		30. Name and address of person wh			e, Print)			0111		0, 2010
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1128 Medical Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death dethesd 100c Ortholl 8. Date of Birth (Month, Day, Social Security Number Birthplace (State or Foreign Country) Age (In yrs. last birthday) Funeral Min. 1 M 2 DF Months Davs Hours Year) 49 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 1 ☑ Yes 2 ☐ No 10e Street and Number 10g. Citizen of What Country? Funeral or items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, injury or other traumatic event, the Medical Examiner Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify. "natural", Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Health and N tem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Livense 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final tillos? Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Unther Examiner STED SIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated and the cause of th Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

OP - 3(-20(0) 29b. Signatur 29c, License number

Registrar
DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death QQN . Decedent's Name (First, Middle, Last) 2. Date of Death Day 8 3. Time of Death Physician/ Kathryn Louise Chrisman September 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Williamsport Williamsport Retirement Home Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Pay, 1 □ M 2 🔯 F Days Hours 214-09-4298 93 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at ones. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 ☐ Yes 2X No Maryland Washington County Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21742 U.S.A. 20014 Rosebank Way Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Records Supervisor Hospital Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Ruth Tetlow Sayles William H. Sayles, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10913 Donelson Dr. Williamsport, MD 21795 K. Arlene Drawbaugh-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Cedar Lawn Mem. Park! 9-13-2010 | Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear dailure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical consequence of Examiner Sequentially list conditions, Examiner Due to lor as a consequence of cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) the attending physiclan Physician/Medical P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
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5 Other (specify) for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Pregnant at time of death ate has been signed by the a page 2 should be detached f 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, No 3 Probably 4 Unknown 1 Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 28d. Describe how injury occurred iniun 5 Pending 1 Tes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Northern

29c. License number

mo

D0063233

29d. Date signed (Month. Dav. Year) 9-9-10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 8 2010 **Physician** Donald Gerald Carson 11:17 A^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 13302 Briarwood Circle Washington County Hagerstown If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 □ F 186-22-1677 80 18,1929 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be rediffed at 1 ∐ Yes 2 🛣 No Maryland Washington County Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 21742 U.S.A. 13302 Briarwood Circle Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" --: any injury or other traumatic events. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. [XYes 2 □ No Yes, Give 1 Never Married 2 Married White 1∐Yes 2XNo 2 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Furniture Company Owner | 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arlene Mae Gahagan Carson Dale Andrew Carson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13302 Briarwood Circle Hagerstown, MD 21742 Dolores H. Carson-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-11-2010 Rest Haven Cemetery Hagerstown, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the fleath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due t r as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Oth Division of Vital Records, <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performe certificate 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certificant of the funeral director, petely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manufer stated. 29a. Certifier Medical within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number è who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

relicia D. Collin	5	1- For State Registrar	Certificate of		,,	teg. No. 2010	2990
Physici Medical Exam		Decedent's Name (First, Middle, Last) Felicia D. Collins			2. Date of Dea Month	Day Year	3. Time of Death 2042 hrs
Medical Exam	mei	4a. Facility Name (if not institution, give street and number)	14	b. City, Town, or Location of Dea		er 13, 2010 4c. County of Death	
		4203 Floral Park Road		Brandywine		Prince George	
Funeral		5. Social Security Number 6. Sex 7. Age ((In yrs. last birthday)	If Under 1 Year If Under 24H Months Days Hours Mi		rth(MM/DD/YYYY) 9. Bir Foreig	
Director		213-19-2290 1 M 2XF 35	Yrs.	Months Days Hours Mi	29, 1975 CountriMaryland		
yna		Usual Residence of Decedent 10a. State 10b. County 10	Oc. City, Town or Location	on			10d. Inside City Limits
* .	Ļ	Maryland 20613	Brandywir	ne			1 Yes 2 X No
Maryland 28a-f show 1 at once.	Director	10e. Street and Number		10f. Zip Code	1	Og. Citizen of What Cou	ntry?
ith the Maryland 23a or 28a-f sho notified at once.		4203 Floral Park Road		20613		U.S.A.	
5-0036 led within 72 hours after death with the Maryland itygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	If Ye	Decedent of Hispanic Origin? (ses, specify Cuban, Mexican, Puert		14. Race - Ameri White, etc.	can Indian, Black,
ter dea		3 Widowed 4 Divorced If Yes, Give Year or Dates:	No 1	Yes 2 X No specify:		Specify: Whi	to
ours af atural'	d by	X I or Dates: 15. Decedent's Education (Specify only highest grade compl	eted) 16a. Decedent	s Usual Occupation (Give kind of		16b. Kind of Business/I	
5-0036 led within 72 hours Hygiene. other than "natur the Medical Exami	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+))	st of working life. DO NOT use re	itired)		
within giene.	omp	11 17. Father's Name (First, Middle, Last)	Beau	itician	o /First haidelle	Beauty Sho	р
21215-0036 nuld be filed within 7 Mental Hygiene. marked other than	Be C	Paul S. Hair			E. Frank		
21214 hould be fil nd Mental E is marked tite event, t	To [19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street and Number or	Rural Route Nur	nber, City or Town, State	, Zip Code)
		Paul S. Hair Father		Floral Park Rd.			
Baltimore, permit. Pages I ar Department of Hes Important: If ite		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State		ion (Name of cemetery, er place)	Date 18, 2010	20c. Location - City or	Town, State
ti. Pag rtment rtant: y or o		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens	Cedar Hill	Cenetery -		Suitland,	Maryland_
Baltimore, MI permit. Pages I and 2.8 Department of Health a Important: If item 27 injury or other traum			M00668 Will	me and Address of Facility liams Funeral F 70 Hawthorne Rd	Home, P.	A.	20640
Physician		28a. Part I. Ent " asease, or complications that caused the failure. Lift only one cause on each line.	e death. Do not enter the	e mode of dying, such as cardiac	or respiratory am	n Head, Md. est, shock, or heart	20640 Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Methadone	intoxicati	on			Death
		or condition resulting in death) Due to (or as a consequence)	ience of):				
	Je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence)	ience of):				
	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated purply resulting in death). Last	lence of):				
outed nd ransit		events resulting in death) Last Due to (or as a consequence of the con					
60, ate be executed hysician and e bunial - transit	Physician/Medical	☐ AMENDED ☐ AMENDED 23a, 27, 2	28a-f,per M	E g908 10.8.10	TT		1
1760, ficate be g physicisthe buni	/Me	IF FEMALE: 23c. If yes, outcome 1 Live birth	of pregnancy			23d. Date of delivery	
Box 6876 death certificat the attending ph	icia	past 12 months?		II death 3Ectopic pregn er (S <i>pecify</i>)	aricy	Month D	ay Year
BO) he death the att hed for	hys	1 Yes 2 No 9 V Unknown 9 Unknown					
ires that the signed by	þ	Part II. Other significant conditions contributing to death be	at not resulting in the un	derlying cause given in Part I.	1 Yes	bacco use contribute to t	ne cause of death? ably 4 🗸 Unknown
ds, equire	Completed				24a. Was a	an 24b. Were aut	opsy findings available
of Vital Records, ng Physician: The law requir ufter this certificate has been s neral director, page 2 should	ğ	r			autop	med? death?	ompletion of cause of
Vital Rec ysician: The l his certificate l	e Co	25. Was case referred to medical		26.Place of Death (Check	1 Yes	2 No 1 Ye	s 2 No
Vits hysicia	70 B	examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatient	3 DOA Other Nursi	ng Home 5	Residence 6 🗸 Other:	Scene
n of ding Ph. After tl		27. Manner of Death 1 Natural 5 Pending	28b. Time of Inj	ury 28c. Injury at Work?	28d. Describe t unk	now injury occurred	
Division tal or Attendir ts after death. al Director: A	icati	2 Accident Investigation Fd 9/13/1		pm factory, office building, etc.		Street and Number or Rur	al Route Number City
Div	Certification:	Suicide OK Could not be	residence	racion,, omiso samenig, ote.	or Town, S Brand	Street and Number or Rur tate); 203 Flora ywine, MD	al Park Rd
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		29a. Certifier 1 Certifying Physician: To the best of my kr			d due to the caus	e(s) and manner as state	d.
To the withing To the compl	Medical	one) 2 Medical Examiner: On the basis of examin and manner stated.	ation and/or investigatio		at the time, date		
	Σ	29b. Signature and title of certifier		29c. License number O.C.M.E.		29d. Date signed (Mon September 14, 20	
		30. Name and address of person who completed cause of deat	h (Item 23a)	3.0.m.E.		Soptombol 14, 20	
361		Melissa Brassell, MD Assistant Medical Ex		nn Street, Baltimore, MD	21201		
St	ate	31. Date filed (Month, Day, Year) SEP 2 0 2010 Agreem	Signature Jack	,		 	
Regist	LC I	JEI WY ZUIU LAMENT I	S. Maria				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3:40 PM Edward E. Cadle Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7. Age (In yrs. last birthday If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) W. Va (Month, 10, 1937 / 1937 Months Hours Min. 1 € M 2 □ F 233-58-4417 73 Director Usual Residence of Decedent Shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. Director 1 XYes 2 No Md. Wicomico Hebron 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 209 W. Church St 21830 Sunny Meadows Apt. United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black White etc. Completed by 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify: nd Mental Hygiene. marked other than "natural", Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) H. S. Graduate Fabricator-Steel Ind. Steel Worker Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 Lowell Cadle Nellie Warren Cadle Department of Health and Important: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elwood Cadle 7404 Spalding Lane Salisbury Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salisbury Crematory 20c. Location - City or Town, State 1 Burial 2 Coremation 3 Removal from State 09/03/2010 Salisbury, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home 11673 Somerset Ave., Princess Anne. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death hock, or heart failure. List only one cause on each line Immediate Cause (Final LUNG Physician CANERO disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CHRONIC OBSTRUC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth
4 Pregnant e Hospital or Attending Physician: The law requires that the death of 24 hours after death.

24 hours after death.

Puneral Director: After this certificate has been signed by the atter in the past 12 months?

1 Yes 2 No Month Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed Yes /2 L death? 1 🗌 Yes 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending Natural within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident 1 ☐ Yes 2 ☐ No Investigation Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 32

Registrar
DHMH 17 Rev 7/2009

State

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ss of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Welkis Delgado Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 2010 29910 1. For State Certificate of Death Rea. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day September 6, 2010 Medical Examiner Melkis В. Delgado 1255 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Atlantic Ocean Ocean City Worcester 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreian Director 577-15-0385 July 8, 1987 23 1[™]M D.C. Country) 2 F Usual Residence of Deceden 10a State 10b. County 10c City Town or Location 10d Inside City Limits 23a or 28a-f show notified at once. D.C. Washington 1 Yes 2 X No Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4518 15th Street, NW 20011 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 1x Yes 2 No specify: Salvadorean 3 Widowed 4 Divorced If Yes, Give Year Specify: White 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than " 21215-0036 12 Construction Self-Employed Department of Health and Mental Hygiene. Important: If item 27 is marked other th injury or other traumatic event, the Medi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Melzer B. Delgado Sara del Carmen Cruz Be ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Melzer B. Delgado/Father 4518 15th Street, NW, Washington, DC 20011 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Sept. 2010 1 xxBurial 2 Cremation 3 Removal from State 13 Gate of Heaven Cemete Silver Spring,MD Donation 5 Other Specify. permit. 21. Signature of Funeral Service License 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 2090 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or Approximate Interval **Physician** failure. List only one cause or ach line Between Onset and /Medical a. Drowning Death **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and trans ian/Medical g physician a UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Fetal death use as 2 past 12 months? Pregnant at time of death Physic 5 Other (Specify) Yes 2 No 9 Unknown 9 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has death? performed certificate ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗸 Other: Scene DOA After this 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification Subiect drowned in ocean within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Natura FOUND: 1 Yes 2 ✔ No Pending Sep 6, 2010 2 🗸 Accident 1005 hrs Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 38 27. 87N,074 42.36W Atlantic Ocean, , determined (Specify) Ocean Homicide 29a, Certifier 1 (Check only

31. Date filed (Month Par 32. Registrar's Signature State Registra

30. Name and wide ss of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

Pamela E. Southall, MD

and manner stated.

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

arked

29d. Date signed (Month, Day, Year) September 7, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav 5:15am Edna Millet Dellimore September 07 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Rockville Nursing Home Rockville Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🗓 F Months 83 127-22-4846 11/13/1926 Cuba Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20906 3210 Norbeck Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify 3 Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Garment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) E. Nation Mildred Burke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14613 Carona Drive, Silver Spring, Maryland 20905 Jean Yvonne Chong - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 09/11/2010 | Brooklyn, New York Cypress Hills Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Sign cure of Functal Convice Co MO1241 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pancreatic Cancer with Metastasis Due to (or as a consequence of): Cerebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hypertensive Heart Disease resulting in death) Last Due to (or as a consequence of): Gangrene of Feet IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital:

Physician /Medical Examiner the death certificate be executed burial-trans

attending physician

certificate

or Attending

death.

To the Hospital or A within 24 hours after

Division or Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Funeral

Director

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Directo

Funeral

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Completed

Be

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exeminer must be notified at

and Mental Hygiene.

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau

filed within 72 hours after death with Hygiene.

Baltimore, Maryland 21215-0036

Examine Physician/Medical use as the signed by the aid þ Completed Be 2 To the Funeral Director: After this completely filled in by the funeral di Certification:

1 ☐ Yes 2[X] No

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day 28b. Time of

Injury at Work?

Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 1 X Natural 5 Pending investigation 2 Accident

6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Medical

3 ☐ Suicide

4 Homicide

1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and tiple of certifier

wo win

D0047330

29d. Date signed (Month, Day, Year) September 08, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph. MD 50 W. Edmonston Dr., Suite 207, Rockville, Maryland 20852 Thomas V.

State Registrar 31. Date filed (Month, Day, Year) SEP 1 0 2010



DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER Day Judith Ann Dayton 09:27 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS - REGIONAL MEDICAL CENTER CUMBERLAND ALLEGANY Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Day Yea 1 □ M 2 😾 F Days Hours Min Months 1940 West Virginia 70 Director 216-38-1614 April Usual Residence of Decedent 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Westernport 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21562 115 Church United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ۾ 1 Never Married 2 Married Yes 2 YNo Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ygiene. her than ' College (1-4 or 5+) Housework Homemaker 12 should be filed with alth and Mental Hygier 27 is marked other t r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnarne) မ Charles Lupton Neva Footen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Kelli Braithwaite/daughter 2434 Ridgetop Drive, Wadsworth, Ohio 44281 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Philos Cemetery 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 09/15/2010 Westernport Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home Wa 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, reading to infinediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events -tran Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Po in the past 12 months?
1 ☐ Yes 2 ▼ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ed by the a 9 Unknown signed by i Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 2 🗌 No 2**X** No Yes Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) : After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ithin 24 hours after death.

the Funeral Director: Ai

mpleted filled in by the fu Accident
Suicide 1 Tes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2

To the F

complet Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 9,12,10 D68455 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENKESHAFI, 12501 WILLOWBROOK ROAD, CUMBERLAND, MD 21502 ARDALAN M.D., 31. Date filed (Month, Day, Year

DHMH 17 Rev 7/2009

State Registrar

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 John Montgomery Dean 12:19 AM SEPTEMBER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHARLES CIVISTA MEDICAL CENTER LA PLATA 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Days Hours Country) Mississippi 3/29/1944 **Director** 425-90-5603 66 Yrs. Usual Residence of Decedent 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1X Yes 2 ☐ No MD Charles Brandywine ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 16211 Woodville Road USA 20613 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 1962—1 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married filed within 72 hours after Maryland 21215-0036 1 Yes 2 X No White Specify. res, Give Year or Dates.1962-1966 3 Widowed 4 Divorced Specify: "natural" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tree Trimmer Commericial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Simmons Dean Grace Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Dean/Wife 16211 Woodville Rd. Brandywine, MD 20613 Department of Healt Important: If item 2 any injury or other once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Glen Burnie, MD Atlantic Crematory 9/10/2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Ineral Service Licensee 22. Name and Address of Facility Huntt Funeral Home Møll90 3035 Old Washington Rd. Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ACUTE tailur Physician/ Spirtory disease or condition resulting in death) UN KNOWN) Medical Due to (or as a consequence of) **Examiner** RESISTANT Methicillin STAPH AUREUS LUNG Alosess YN KKOWN Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of HEAD AND METASTATIC CANCER OF LINKKOWA been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical EMPL unckalow w Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed? Yes 2 Yes • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ၀ 1 Tes 2 No Other: 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu 29d. Date signed (Month, Day, Year)

BB541

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Registrar

DHMH 17 Rev 7/2009

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMUELJ. KLEIMAN, MO

SEY 09

31. Date filed (Month, Day, Year)

D0058505

11711 LIVINGSTON RD, FORT WASHINGTON, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Frank Demuth Ervin, Sr. September 2010 6:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 97 Bay Drive Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year March 28, Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Voar 214-28-2709 XXM 2□F 79 Director 1931 Washington, DC Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notified at Maryland Anne Arundel Annapolis Director 1 ☐ Yes 2011No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's 97 Bay Drive 21403 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner mana Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married XX Married XYes 2 □ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Korea 1 ☐ Yes 2 ▼No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Builder Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward John Ervin Adelaide Demuth ပ 19a. Informant's Name/Relationship (Type. Print)
Margaret Ervin/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 97 Bay Drive Annapolis, Maryland 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Removal from State Baltimore Crematory 9/8/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 200 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed burial-tra Due to (or as a consequence of): P.O. Box 68760, ettending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) s been signed by the should be detached □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an page 2 s certificate has autopsy perform 1 □Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one examiner? Hospital: Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death
1 Natural
2 Accident 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? After Division 5 Pending investigation spital or Attendi ours after death. neral Director: A death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 24 hours a 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 and manner stated. 29b. Signatu License number 29d. Date signed (Month, Day, Year)

CH10+1 State

Registrar

31. Date filed (Month, Day, Year) SEP 0 8 2

name and address p

32. Registrar's Signature

B. park

Item 23a (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Patricia A M Albina Bernadette Frankton August 2010 9:20 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 12747 Hog Lot Road Ridgely Year | If Under 24 Hrs. | Caroline Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 □ M 2 □ F Months Days Hours Min Director 213-34-5819 Feb 20 1937 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If flem 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Caroline Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12747 Hog Lot Road 21660 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No þ Specify Specify: Caucasian 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Frank Drexler Bertha Margaret Backhause 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 any injury or other troone. Roland C. Frankton Husband PO Box 781, Ridgely, Maryland 21660 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Capitol Crematory 8/31/2010 Dover, Delaware 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lights 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Thrist Immediate Cause (Final **Physician** -acture disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 □Yes 2 No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) 1 Yes 2 No Certification: To Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No

Box 68760. P.0. Records, Division of Vital or Attending death. 24 hours after death filled in by Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number HU057821

📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Valerie Goodman, 2540 Centreville Road, Centreville, Maryland M.D 32 Registrar's Signature

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

3 Suicide

29a. Certifier

Medical

State Registrar

4 ☐ Homicide

(Check only

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 09 Day 15 Michael Arlington Fulmer Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2039 Maryland Highway Mt Lake Park Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth Funeral Months Days (Month, Day, 05 10 Director 214-52-1595 58 Usual Residence of Decedent or 28a-f show 10a. State 10b. County Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director MD Garrett Mt Lake Park 10e Street and Number 10g. Citizen of What Country? Funeral 2039 Maryland Highway 21550 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 ☐ Yes 2 承 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Coal Miner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) မ William Fulmer Inez Hershman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan M Fulmer-wife 2039 Maryland Highway, Mt. Lake Park, MD 21550 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ■ Burial 2 □ Cremation 3 □ Removal from State 9/19/2010 4 Donation 5 Other (Specify) Pleasant Valley Cemetery Oakland, MD of Funeral Service Licensee Signatur 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ MANTI disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as nse yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death been signed by the a should be detached f P.O. Part II. **Other** si**gnificant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate Yes Hospital or Attending Physician: 25. Was case referred to medical Division of Vital completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 1 Tes Certificate: To 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 24 hours after death. Funeral Director: A 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, 29d. Date signer

 p^{M}

11:10

9. Birthplace (State or Foreign Country)
MD

10d. Inside City Limits

Approximate Interval Between

Onset and Death

1 Yes 2 No

2010

Garrett

White

Coa1

Month

Day

1 Yes 2 No

Year

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

(Item 23a) (Type, Print

	State Registrar 1. Decedent's Nan	ne (First, Middle, La	ast)		Cel	rtificate of	Jean	2. Date of Deat	eg. No. h		3. Time of			
n		Giaunetto						Month 09	Day	2010	165			
al er			ive street and number	er)		4b. City, Town, o	Location of Death	4c. County of Death						
	418 Hero					Chester		10:11	W-1 (Ct-1-					
	5. Social Security 121–03–4	175	Sex 1 M 2 □ F	Age (In yrs. la	98 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 08 / 15 / 1	Year) 912	9. Birthplace (State or F Country) 11 11 21 3				
	Usual Residence of	10b. County		10c. City	, Town or Lo	cation					10d. Inside Ci			
ţo	MD	Kent		Ches	tertow	m					1 ☐¥es			
Director	10e. Street and No	umber				10f. Zip Code		1	0g. Citizen	of What Co	ountry?			
	418 Hero	n Point				21620			ISA					
y Funeral		rried 2 Married	12. Was Decede Armed Force 1 Yes 2 If Yes, Give	es?	ŀ	Was Decedent of H If Yes, specify Cuba 1 □Yes 2ሺ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Black, Whit				
d by	3 🖾 Widowed	4 Divorced	Year or Date	es:						WI	ite			
olete		15. Decedent's E ecify only highest gi	rade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	ing	16b. King (of Business	rindustry				
Completed	Elementary/Sec 12		College (1-4d	or 5+)	Comme	rcial Sal	Lesman		Fulle	r Bru	sh Comp			
BeC	17. Father's Name	e (First, Middle, Las	it)				18. Mother's Name	e (First, Middle, I	Maiden Sui	rname)				
은	Carmine	Gerardi			1		Pia Silve							
		Name/Relationship			1		and Number or Rur				Zip Code)			
	Susan Pe	etraglia ·	- Niece	20h. Pl	ace of Dispo	sition (Name of	t NE Wash				Town, State			
	1X Burial 2	•	Removal from Sta	ate Ce	emetery, cre	matory or other pla	10ck 09/			•				
		Funeral Service Lice		י שאַ			ess of Facility Fe1							
	Ku	kg H	effects.	ω	1:	30 Speer	Road Ches	tertown	, Mar	y1and	21620			
	23a. Part 1. Enter shock, or he Immediate Cause disease or condit	eart failure. List onl e (Final	mplications that cau ly one cause on eac	sed the death h line. PTIC		ter the mode of dyi	ng, such as cardiac	or respiratory arı	rest,		Approxima Interval Be Onset and			
Examiner	resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):													
			d		d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									
	23b. Was decede in the past 1	2 months? 2 □ No	23c. If yes, outco 1 ☐ Live bir 4 ☐ Pregnal	th 2 ☐ Fetal nt at time of d	death 3		гу		230	d. Date of de Month	elivery Day			
by Physician/Medical	23b. Was deceded in the past 1 1 Yes 2 9 Unknow	2 months? 2 No vn	23c. If yes, outco 1 ☐ Live bir 4 ☐ Pregnal	th 2☐ Fetal nt at time of d vn	death 31 eath 51	Other (specify)		23e. Did to	bacco use	Month contribute				
e Completed by Physician/Medical	23b. Was deceded in the past 1 1 □ Yes 2 9 □ Unknow Part II. Other sign	2 months? 2 □ No vn nificant conditions	23c. If yes, outco 1 ☐ Live bir 4 ☐ Pregnar 9 ☐ Unknow	th 2☐ Fetal nt at time of d vn	death 31 eath 51	Other (specify)		1 Y 24a. Was a autop perfor 1 Yes	bacco use es 2 1 1 an sy med? 2 1 No	Month contribute	to the cause of Probably 4 Dautopsy findings completion of			
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10-07001
Morris Green

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

forris Green		State of 1- For State	Maryland / I	Depar		Health ar			ne ¯	20	110 29	91
Physici Medical Exam		Registrar 1. Decedent's Name (First, Middle,Last) Morris Green						2. Date Mon Sep	of Death	p. No. Day Year 11, 2010	3. Time of Death 1357 hrs	h
		4a. Facility Name (if not institution, give stre Western Maryland Health Sys			4	b. City, Town, o Cumberlan				4c. County of Death Allegany		
Funeral Director		5. Social Security Number 218–16–2845 6. Sex			st birthday) Yrs.	If Under 1 Ye Months Day					Birthplace (State or Foreign Country)	
Maryland 28a-f show any d at once.	ctor	Usual Residence of Decedent 10a. State 10b. County MD Allegany 10e. Street and Number	10		own or Location				100	g. Citizen of Wha	10d. Inside City 1 X Yes 2 (
i with the Maryland ms 23a or 28a-f sho be notified at once.	al Director	123 C Main St.				21562				United S	States	
r death or ite	by Funeral	1 Never Married 2 Married 1 1 3 Widowed 4 Divorced 1 1 or or or or or or or or or or or or or	s, Give Year Williates:] No W 2	If Ye	Decedent of Hi s, specify Cuba Yes 2 X No	n, Mexican, F	uerto Rican, o	etc.)	White, Specify:	white	ί,
11215-0036 Id be filed within 72 hours afte fental Hygiene. narked other than "natural", event, the Medical Examiner	Completed	unknown	ghest grade comple College (1-4 or 5+)		during mo	s Usual Occupa st of working life ucker			1	16b. Kind of Busi Paper Ma	ness/Industry anufacturer	:
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Middle, Last) Frank G. Gree					Luc	y Mae	Grov			
MD 21 d 2 should lth and Me n 27 is ma	То	19a. Informant's Name/Relationship (Type, John Deniker/ frien	Print) :d					estern	port	er, City or Town, , MD 21	562	
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		20a. Method of Disposition 1 X Burial 2 Cremation 3 F 4 Donation 5 Other Specify:	emoval from State	Cre	ematory or other Veteran	s Cemet	ery		010	Flintsto	ity or Town, State one Marylan	ıd
Ball permit Depart Impor injury		21. Signature of Funeral Service Licensee	Bal		111	Church	St, W	<i>l</i> estern	port		and 21562	
Physician /Medical Examiner		23a. Part I. Enter the disease, or complicating failure. List only one cause on each ling Immediate Cause (Final disease a. H						diac or respira	tory arres	st, shock, or hear	Approximate In Between Onse Death	
	L	Sequentially list conditions, b	o (or as a consequ									
ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o (or as a consequ o (or as a consequ									
), be executed sician and urial - transi	dical	Z UNPENDED and	ENDED 23a	ı,pt.	.II,27,	28a-f p	er me	g908 1	0-14	-10 vt		
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicitely filled in by the funeral director, page 2 should be detached for use as the buri	ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of Live birth Pregnant at tim Unknown		2 Feta	il death 3 er (Specify)	Ectopic p	regnancy	- ili saamaa	23d. Date of de Month	elivery Day Yea	ır
i, P.O. Baires that the designed by the	by Phy	Part II. Other significant conditions cont Diabetes, Normal	•		Ū	, ,	given in Part	I. 23e			re to the cause of deat	
Records, The law require ficate has been signings 2 should b	Completed	Diabetes, Norman	pressure	= 11y	посерп	aius		_	a. Was an autopsy perform Yes 2	prid ed? dea	ere autopsy findings avair to completion of causath? Yes 2 1	
ital Recician: The l	a	25. Was case referred to medical examiner?	al: 4 🗀 🛌 i t	2 7 5	D/O to the stant		Othor	neck only one)			
Division of Vital lat or Attending Physician: rs after death. al Director: After this certiled in by the funeral director.	tion: To	1 Natural 5 Pending	8a. Date of Injury (Month, Day, Year)	2	R/Outpatient 8b. Time of Inj unknown am.	ury 28c. Inju	ry at Work? Yes 2 🗶 N		scribe ho	w injury occurred fell	Other:	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:	4 Homicide determined	28e. Place of Injury (Specify) res	iden	ne, farm, street,			28f. Loc or Wes	cation (Str Town, Sta tern	eet and Number te) 25701 port, Mo		r, City
To the Hospital within 24 hours. To the Funeral completely filled	Medical	one) 2 Medical Examiner: On t										
	Σ	29b. Signature and title of certifier	It	_		29c. Licens				29d. Date signed September 1	(Month, Day, Year) 2, 2010	
	0	30. Name and address of per on who compl Jack Titus MD. Deputy Chie	eted cause of death f Medical Exam		•	Street, Bal	timore, MI	D 21201				
St Regis	ate	31. Date filed (Month, Day, Year) SEP 1 4 2010	32 Registrar's S	Signature	hart	-						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010

	1	For State Registrar			olalo c	,, ,,,,	ai y iai i	C			of D		i ana i	VIOITE		Reg. N	21	110	29	920
Dhusisian/		1. Decedent's Name	e (First, Middle,	Last)											e of De	ath		Va	3. Time of	Death
Physician/ Medical		Mildre					!							Mo	nth O	<u>9/0</u>) 17/2(010	7:4	0a ^M
Examiner	4	4a. Facility Name (if		_	et a <i>nd n</i> un	nber)			4b	. City, 1	Town, or l	Locatio	n of Death			4	c. County	of Death		
	Į	ASDUTY- 5. Social Security Nu	- Solomon			7 4	//	() () () ()) 15	Llaslas	1 Voor	If I ha al	0.4 11							
Funeral Director		578 14 41	150	6. Sex	M 2 XXF	7. Age		as <i>t birthda</i> Yrs	Mo	Under onths	Days	Hours	er 24 Hrs. Min.		e of Bir onth, Da 8, 1	y, Year)		Coun	olace (State or try) ngton DC	_
how at a	- 1-	Usual Residence of 10a. State	10b. County			\neg	10c. City	y, Town or	Locatio	on								1	0d. Inside Cit	ty Limits
he Maryland or 28a-f sho notified at		Maryland	Prince	Georg	e [†] s			Bowie	0										1 🗆 Yes	
or 28	5	10e. Street and Num			,			DOWL		0f. Zip	Code					10g. C	Citizen of V	Vhat Cour	ntry?	
leath with the items 23a con the remust be remust be Funeral		13019	Martha (Choic	e Circ	le				20	0720					Ur	nited	State	3	
death item		11. Marital Status			. Was Dece Armed Fo	dent E	ver in U.S	5. 1	3. Was	Decede	ent of His fv Cuban	panic C	Origin? (Spe	ecify Yes	or No-		14. Race	e - Americ	an Indian,	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Department of Health and To send the than "natural", or items 23a or 28a-f show many injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		1 ☐ Never Marri 3XX Widowed		ed	1 ☐ Yes If Yes, Giv Year or Da	_2 🔼 N re	No				XXNo				,		Specify:	k, White, Wh		
"nat edica		(Spec	15. Decedent cify only highes					(G	ive kind	of work	Occupat done du	tion i <i>ring m</i> o	ost of work	king		16b.	Kind of Bu	isiness In	dustry	
vithin 72 hours at lene. r than "natural" the Medical Ext		Elementary/Second 12	onday (0-12)		College (1	-4 or 5-	+)	life	o. DO NO Off		^{retired)} Manae	ær					Roard .	of Ed.	cation	
Hygi other ent, 1	}	17. Father's Name (F	First, Middle, La	ast)				L		100			ther's Nam	ne (First,	Middle,				ICALLION	
d be findental	2	Charles	Barton										Laur							
should and N is ma auma		19a. Informant's Na			Print)			19b. M	ailing A	ddress	(Street ar	nd Num	ber or Run	al Route	Numbe	r, City c	or Town, S	tate, Zip (Code)	-
and 2 Health im 27 her tr		Paul E. G		9								ice	Circle							
ge 1 and the of H	2	20a. Method of Disp 1 🔀 Burial 2	☐ Cremation		moval from	State	C	lace of Di emetery, c	remato	ry or ot	her place,		Sept	II, 2	2010	20c. l	Location -	City or To	wn, State	
artmer ortani injury	ŀ	4 Donation 21. Signature of Fun					<u> </u>	Washir	gton	Nat	ional	Cen	etery	T	1.1	Sui	tland.	Mary	land	_
Depa Impa any		House	XA	lac	1 m	00	257		Ferr	y Ro	ad, C	lint	on, MD	runer 207	тал н 735	iome,	Inc (633 (ld Alexa	andria
	1	shock, or hear	he disease, or on t failure. List or	nly one c	ause on ea	ch line.								-	-				Approximate Interval Bety	ween
Physician/ Medical	- 1	Immediate Cause (F disease or condition resulting in death)		a. :	CO M!	CLIC (or as a	consequ	ience of):	OF	3 7	ME.	150	A/AL	ZHE	ME	23	D15 F	236	Onset and D	
Examiner		Sequentially list cor	nditions,	b																
xecuted n and al-transit		if any, leading to im cause. Enter Under Cause (Disease or i	lying		Due to	or as a	consequ	ience of):												
tificate be executed ng physician and as the burial-transit Medical Exami		that initiated events resulting in death) L	6	с.	Due to	or as a	consequ	ence of):												
ificate be ending physiciar as the buriar				d.,																
		F FEMALE:																		
eath cert attendin I for use ician/I	2	23b. Was decedent in the past 12 n	nonths?	230	. If yes, out 1 Live 4 Preg	Birth 2	2 🗌 Feta	l death	3								23d. Dat Mor	e of deliventh	*	'ear
iries that the death cel signed by the attend id be detached for use detached for use death by Physician/	, [1 Yes 2 X 9 Unknown	(I No		g Unkr		time or d	leam	5 🗆 Oti	ner (spe	:City)						1170			-
s that t gned b se deta by P I		Part II. Other signifi	icant condition	ns contri	buting to d	eath bu	it not resi	ulting in th	ne under	rlying ca	ause give	n in Pa	rt I.	23	e. Did t	obacco	use contr	ibute to th	ne cause of de	eath?
requires been sig should by															1 🗆	Yes 2	2 X No	3 🗌 Pro	bably 4 🗆 t	Jnknown
The law require cate has been si page 2 should be Completed	.													24	a. Was autoj	psy	P	rior to co	psy findings a mpletion of ca	
cate h														1	perfo Yes	ormed?		leath?	2 🗆 No	
certifi rector		25. Was case referre examiner? 1 ☐ Yes 2 ☐		Hos	pital:						Other		eath (Chec	k only or	ne)					
r this c eral dire		27. Manner of Death			28a. Date	of injun	/	ER/Outpa 28b. Time		$\overline{}$	c. Injury	4 🕒	Mursing Ho				6 Othe)	
anding sath. or: Afte he fune ficat		1 Accident	5 Pending	ation	(Mon	th, Day,	Year)	injur		м	work?			200. 20	oonbe i	1011 11110	ny ocoano	,		
or Attending P after death. Director: After t in by the funera		3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could n determin		28e. Place buildii		y - At hoi (Specify)		street, f	factory,	office				cation (S			r or Rurai	Route Number	er,
To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attendicompleted filled in by the funeral director, page 2 should be detached for use Medical Certificate: To Be Completed by Physician/		29a. Certifier 1	Certifying I	Physicia	in: To the b	est of n	ny knowie	edge, dea	th occu	red at the	ne time, o	date an	d place, ar	nd due to	the ca	use(s) a	and manne	er as state	d.	
the H the F mplete	_	only one) 3	☐ Medical Ex☐ Certifying I	Nurse P	ractioner:	To the b	est of my	knowledg	vestigati je, death	n occum	ed at the	time, da	ate and plac	ce, and d	e, date a lue to th	e cause	(s) and ma	nner as st	ated.	nner stated.
2	-	29b. Signature and	action of certifier	130	11					29c.	License i	number	· - 19			29d. Da	ate signed	(Month,	Day, Year)	
,	2	30. Name and addre	ess of person w	ho com	pleted caus	e of de	ath (Item	23a) (Tvp	e Print\	1	221	93	18			9	18//	D		
584		50H	N H	W	EIGE		/ (I.OIII		? (~ C		FR	FDF	RICO	k.,	mi		206	28		
State	3	1. Date filed (Month	EP 10	2040	32/R	egistrar	's Signati	ure	/	0.0					-30/					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1. Decedent's Name (First, Middle, Last)		Death	2. Date of Dea			me of Death
Physicia /Medic		Robert Wesley Gardner			September 1	er 9, 20	010 7:	25 A M
Examin	er	4a. Facility Name (If not institution, give street and number)		or Location of Death		4c. County		
		Talbot Hospice House 5. Social Security Number 6. Sex 7. Age (In yrs. last bi	Easto	on If Under 24 Hrs.	8. Date of Birth		1bot 9. Birthplace (S	State or Foreign
Funeral Director		219-18-9046 1 1 3 M 2 □ F 87 Usual Residence of Decedent	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day Sept. 3	(, Year)	Maryla	
23a or 28a-f show ust be notified at	tor		on or Location idge1y					ide City Limits
r 28a	Director	10e. Street and Number	10f. Zip Code			10g. Citizen of V	Vhat Country?	
23a c		24319 Deerfield Lane	2166	50		United S	States o	f Amer
"natural", or items	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 13 ☐ Yes 2 ☐ No 1943— 15 Yes, Give Year or Dates: 1945	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🎛 No		ecify Yes or No- Rican, etc.)	Blac	e - American Indi k, White, etc.	
an "natura Medical E	Completed		a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of worki	ing	16b. Kind of Bu		
er than	Comp	Elementary/Secondary (0-12) College (1-4or 5+)	Carpenter			Boat		
marked other th	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name			ne)	
narked c	2	Wesley Theodore Gardner		Mary		mmerman	0.4. 7. 0.4.	
If item 27 is marke or other traumatic			b. Mailing Address <i>(Stree</i> : 3 Colonial	Court, Ea				
tem 2	1		of Disposition (Name of ery, crematory or other pla		Date		City or Town, Sta	ate
ortant: If it		4 Donation 5 Other (Specify) Steve	ensville Ceme	etery 9/13	· 1		ville, M	larylaı
any ir		21. Signature of Funeral Service Licenses	12 South S	^{ess of Facility} Moo Second Str				21629
aminer		Due to (or as a consequence		NIC DIBSTE	u67112	rucumo	way wo	t and Death
	al Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or	e of):	NIC VBSYCI	ua 102	rulyo	MRY UNO	NTH
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ORIGINAL

DHMH 17 Rev 1/2001

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1 - State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Henriette Doll Harman prembe /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Assisted Living Well Anne Arundel Millersville If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖾 F Months 86 Yrs 215-16-1968 Director Jan. 18,1923 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experiment, ust be notified at 10a. State 10b. County 10c. City, Town or Location Director MD Anne Arundel Millersville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 265 W. Pasadena Road 21108 USA **Funeral** 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hubert Doll Katarina Rotarius ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Doll Harman/Daughter 916 East 18th Street Chester, PA 19013 Sept. 03, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, INC. Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fall the List hilly one cause on each line. Immediate Cause (Final End Stage **Physician** dene disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-transit and Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown 5 Other (specify) signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes is certificate has been s director, page 2 should Completed 24a. Was an autopsy 1 ☐ Yes 2 🐼 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) Veterans Hasy Melersville, MD 21108

Year

2018

Black, White, etc

9:004 M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 XNo

Germany

White

e Funeral C

To the I within 2

Medical

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Nas

SEP 0 8 2010

Registrar DHMH 17 Rev 1/2001 29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

ns. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8601

32. Registrar's Signature

State Registrar PAULTNE

31. Date filed (Month, Day, Year)

758

aires

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DALEY

SEP

RICHARDS

32. Registrar's Signature

Rusera

1500 Pennsylvania Avenue

Hagerstown, MD 21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 29924 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Herbert Leroy Holden 20.28PM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** ST AGNES BALTIMORE HOSPITAL Baltimore city If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day,) April /, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** , Year) 1932 Months Days Hours Min. 210-24-7512 78 Cromwell Cremnsyl Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evantinat must be notified at Baltimore County Maryland Sparrows Point Director X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7308 N. Dakota Avenue 21219 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? XX19es 2 □ No 9/22 If Yes, Give 10/9/52 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 72 hours after 1 Never Married XX Married Saltimore, Maryland 21215-0036 1 □Yes 2 No White Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Supervisor Manufacturing alth and Mental Hv. 7 is mark. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Leo Holden Mary Jane Price ပ 19a. Informant's Name/Relationship (Type. Print)
Theresa E. Knowles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1963 Merritt Blvd., Dundalk, Maryland 21222 Health a injury or other permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other 20a. Method of Disposition

T☐ Burial 2 ☐ Cremation ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State RD, Three Springs, Monroe Valley Cemetery 9/11/2010 Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M-00849 Lochstampfor Funeral Home, Inc. 48 S. Church Street Out 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1251 **Physician** 10 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner days PNEUNONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): SENILITY INKNOWN the burial-trar resulting in death) Last Due to (or as a consequence of): physician 68760 certificate be Physician/Medical as attending Box IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. the Tyes 2 No. 9 Unknown þ signed t be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as S autopsy page performe certificate NA 2 \(\overline{N} \) 1 ☐ Yes 2 ☐ No Vital 1 □ Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Hospital 1☐Yes 2☑No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient After this 2 ER/Outpatient 3 DOA Certification: To 5 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred ospital or Attending hours after death. Division 1. Natural 5 Pending in 24 hours area cite fine Funeral Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

5/7 8+1 State

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31. Date filed (Month Day, Year)

JANE

A 3455 W
32. Registrar's Signature

ATTENDING

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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BALTIMORE

2010

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 2, 2010 Pear1 Jean Hanson 6:00 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Mandeville House Waldorf Charles 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💆 F 014-03-9987 Min 94 Months Days Hours June 5, Year 916 Massachusetts Director Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No MD. Charles Waldorf 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 3085 Eutaw Forest Drive 20603 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Midowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bank Teller Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Ments Important; If item 27 is marked any injury or other Napoleon Guay Evelina LaMav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Hanson (Son) 3085 Eutaw Forest Dr. Waldorf, MD. 20603 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Atlantic Crematory Sept 8, 2010 Glen Burnie, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington rd. Waldorf. MD. 21. Signature of Funeral Service Licensee m01190 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atheruscleratio wronary vascular disease disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami physician and s the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Oregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant g ☐ Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Aczheiner's Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Atrial fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 astes Jorasis 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending injury work?
1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 Records, Division of Vital 24 hours a

Baltimore, Maryland 21215-0036

completed filled in by

31. Date filed (Month, Day, Year) Registrar

(Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CASTLENT

120 OUD LING CTR, STEIN

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Critiying Nurse Prooficings To the season my incomined at the time, date and place, and due to the cause(s) and manner stated.

D5359~

29d. Date signed (Month, Day, Year) 9/2/10

WALPORF

Medical

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ter o	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No		If Yes,	specify Cuba	lispanic Origin an, Mexican, P	uerto Ri	can, etc.)		Black, Whi	te, etc.
rs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Specify: Specify:						pecify:	White
hou ttura	ed	15. Decedent's Ed		16a. D	ecedent's	Usual Occup	ation			16b Kind	of Business	/Industry
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2 sh and is m		19a. Informant's Name/Relationship			-				Route Number •			Zip Code)
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of H		20a. Method of Disposition	Co	ace of D	isposition crematory	(Name of or other place	e)	Dat		20c. Loca	tion - City o	Town, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Eventies 1: ust the netitied at once.		12 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		e of	Heav	zen Cei	metery	Sej	pt. 11 010	Silv	er Sp:	ring, MD
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		shock, or heart failure. List Miy Immediate Cause (Final	one cause on each line.			,	3.		, ,			Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Sepsis									
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p #	ine	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ									
executed n and al-transit	xamine	that initiated events	c. Severe Dehyd:									
ø ⊏ <u>ø</u>	ш	resulting in death) Last	Due to (or as a consequ									
ficate be ex physician s the burial	ical		d. Acute Renal 1	Fail	ure							
tifica ng ph as th	led pa											
eath certific attending p for use as f	Ę	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar		۰۵۰۰					230	d. Date of de	elivery
deat a attr	icia	in the past 12 months? 1 □Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de			pic pregnanc er <i>(specify)</i> _	у				Month	Day Year
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that led b		Part II. Other significant conditions of	ontributing to death but not resu	Iting in th	ne underlyi	ing cause giv	en in Part I.		23e. Did tol	oacco use	contribute	to the cause of death?
uires sigr d be	d by								1 □ Y€	s 2 🕇	No 3□ F	Probably 4 Unknown
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The gate page	ő								1 Yes	ned? 2 ∐*No	death? 1 ☐ Ye	s 2□No
sician: The la certificate ha irector, page 2	Be	25. Was case referred to medical examiner?						Death (Check only on	e)		
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ng Pl ter th		27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Tin Inju		28c. Injur Worl	y at	28	d. Describe ho	w injury c	ccurred	
ath. r: Af	atic	1X Natural 5 ☐ Pending 2 ☐ Accident investigation			М		Yes 2 □No					
Atte	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm	, street, fa	ctory, office		28			Number or F	Rural Route Number,
al or s afte l Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify)					City or Towl	ı, State)		
spits nours neral	a C	29a. Certifier 1 Certifying Ph	ysician: To the best of my know	wledge, o	death occu	irred at the ti	me, date and p	place, ar	nd due to the o	ause(s) a	nd manner	as stated.
e Ho 124 h e Fui letely	edical	(Check only 2 Medical Examone)	niner: On the basis of examinat and manner stated.	ion and/	or investiga	ation, in my o	pinion, death	occurred	d at the time, d	ate and p	lace, and du	ie to the cause(s)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, E	Me	29b. Signature and title of certifier	4			29c. Licens	e number		2	9d. Date	signed (Mor	nth, Day, Year)
->-0			<u> </u>			D/	0000		-			

State

31. Date filed (Month Pay Year) 2010

30. Name and address of person who completed cause of ath (Item 23a) (Type, Print)
Kshama Garg, MD 1500 Forest Glen Road, Silver Spring, MD 20910

29c. License number D60826

Sept. 9, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 23a,25 per me,g907,09/23/2010dhb Certificate of Death Reg. No. for State Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Iserlynette Jones 05:30 PM Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Florida **Funeral** Months Days Hours Min (Month, Day, Year)
March 16 1 M 2 D 593-03-9689 Director 29 Yrs 1981 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injuy or other traumatic event, the Medical Examiner must bu Funeral 918 Mulberry Ave. 21740 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Receptionist 10 Goodwill Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Isaac Lee Jones Linda K. Shoemaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda K. Shoemaker Jones (Mother) 918 Mulberry Ave. Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 1y 2 2010 28, Ju14 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland Smithsburg Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Davis Funeral Home J.L.MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 JAVIS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis Mr. Lower. Litus disease or condition Medical resulting in death) Due to (or as a nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying CERTIFICATION APPROVED BY MEDICAL EXAMINER Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 100 Pregnant at time of death
Unknown 5 Other (specify) Month Day g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 2 🖳 № 3 🗆 Probably 4 🗆 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No 1 🗌 Yes funeral director, 25. Was case referred to medical l e 26. Place of Death (Check only one) examiner? မ 2 46 Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide 24 hours after death Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) D6 258 k 2010 2220 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Hegershown 251 E. Antietam

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

32.

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland		rtment of F				giene, Reg. No.	2 A I A	29928
			Decedent's Name (First, Middle, La	ist)		,				2. Date of Dea	ith		3. Time of Death
	Physicia /Medic		Lillian 1	lae i	10	hns	01		42	Month	Day) 2010	10,53cm
	Examin		4a. Facility Name (If not institution, gir	re street and number)			4b. City, Town, or	Location	of Death		4c. (County of Death	
J2	-		5. Social Security Number 6.5	WERS4DE	o (In vrs la	ast birthday)	If Under 1 Year	If Under	24 Hrs. 1	8 Date of Birtl	h	77/1/CFC	place (State or Foreign
o	Funeral Director			1 □ M 2 □ XF		5 Yrs.	Months Days	Hours	Min.	8. Date of Birtl (Month, Day 11/07/1	914	Cou	ntry) yland
	p ,		Usual Residence of Decedent						,				
	laryla shov	ō	10a. State 10b. County			, Town or Lo							10d. Inside City Limits 1 X Yes 2 No
	the N	Director	MD Kent 10e. Street and Number		Mill	ingtor	10f. Zip Code				10a. Citiz	zen of What Cou	
	h with		214 Middle Stree	r			21651				USA		,
	ems 3	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S	3. 13. V	Vas Decedent of H f Yes, specify Cuba	lispanic Ori	igin? (Spec	cify Yes or No-	1	4. Race - Amer Black, White,	
36	or it	by Fι	1 ☐ Never Married 2 ☐ Married 3 ☐ Midowed 4 ☐ Divorced	1 Tes 2 X	10		□Yes 2 XNo			iloan, oto.)		Specify:	etc.
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21215-0036	filed within 72 hours after death with the Maryland thygene. the than "natural", or items 23a or 28a-f show ent, the Medical Examinat must be retified at	Completed	(Specify only highest grant Elementary/Secondary (0-12)		+)	(Give	kind of work done of OO NOT use retired	durina mos	t of working	g			,
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gue	2 should be filed and Mental Hygi Is marked other aumatic event, II	Be	17. Father's Name (First, Middle, Last)					er's Name Lse Go	(First, Middle,	Maiden S	Surname)	
Z	should be and Mental marked c	ပ္	Emmitt Kennedy 19a. Informant's Name/Relationship	(Type Print)		19h Mailin	g Address (Street				r City or	Town State 7	in Code)
Ma	and 2 sealth arm 27 is	, i	Louis Duckery - G			1	aple Lane						
ore,	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Healin and Menth Hygiene. If of Healin and Menth Hygiene. If of Healin 21 is marked of the titlene. In a 23a or 28a-f show or other traumatic event, the Medical Examiner must be refitted at	1	20a. Method of Disposition		20b. Pl		sition (Name of natory or other place		Da			cation - City or T	
altimore, Maryland	Page ment ant: II		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Cont			n Ceme			09/16	/2010	olds	sboro, M	laryland
Balt	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service Lice	1500	0		Name and Addres		r.c.r.				Newnam
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death								Approximate Interval Between
8.	Physician		Immediate Cause (Final disease or condition resulting in death)	.a	nca	MIGI	infor	ncti	on				Onset and Death
W.	/Medical Examiner		resulting in death)	Due to (or as a	a consequ	ence of):	1						
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	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	a Kr	10-01	tons	184						
Ö,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as	consequ	ence of):	•						
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Вох	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3 □	Ectopic pregnancy Other (specify)	у			2	3d. Date of deli- Month	Day Year
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oro	w requir	sted	Janeval dec	MIN TU	/ y.f	ar				1 🗆 Y	es 21	[No 3 Pro	bably 4 Unknown
Records,	has the	Completed								24a. Was a autop perfor	sy	24b. Were aut prior to c death?	opsy findings available ompletion of cause of
			25. Was case referred to medical					00.5		1 □ Yes	2 No	1 ☐ Yes	2 □ No
	Physician: r this certific ral director, I	o Be	examiner?	Hospital: 1 ☐ Inpatie	nt 2 🗆 E	ER/Outpatien	t 3 DOA Othe			(Check only or e 5 □ Besid		☐Other (Spec	ifu)
0 _	ding Ph h. After th funeral	L:U	27. Manner of Death 1 S Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		28b. Time of Injury	28c. Injur			Bd. Describe h			.97
Sio	Attending It death. Sctor: After by the fune	catio	2 Accident investigation 3 Suicide 6 Could not b				M 1 🗆	Yes 2□					
Division of	pital or Atten ours after deatl eral Director: filled in by the	ertification: To	4 Homicide determined		iry - At hor :. (Specify	ne, farm, stre	et, factory, office		28	3f. Location (S City or Tow		l Number or Rui	al Route Number,
_	spital hours neral y filled	O	29a. Certifier 1 Certifying Pl	nysician: To the best of	of my knov	vledge, death	occurred at the tir	me, date ar	nd place, a	nd due to the	cause(s)	and manner as	stated.
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledical	one)	miner: On the basis of and manner sta	examinat ited.	on and/or inv			ath occurre				
	/	Σ	29b. Signature and title of certifier	Mula IM	^		29c. Licenso	e number	25			signed (Month	, Day, Year)
	ms		30. Name and address of person who	1 0 0 0	eath (Item	23a) (Type, I	Print)	0.1	1 0	1 1	(and	10111
	Stat	e	31. Date filed (Month, Day, Year)	32. Repstra	tr's Signati	ure _	CIVE I	100	17	# /p/18		10116 0	VU/ T
	Registra		SEP 14	2010 Deno	w	J. A	ave						
DUL				-									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2010

			1 - State of Ma Registrar	ryland / Depa Cert	artment of F tificate of L			ene g. No. 201	0 29929						
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death						
	Physicia Medio		Margaret Etta Klingman				Month 09	05 2010	1030 PM						
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of De	c. County of Death						
	,		Hospice of Queen Anne's Inc.		Centrevi			Queen Ai	Queen Anne's						
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) 07/23/19	(ear) 9. B 0 19 Oh:	irthplace (State or Foreign Jountry) LO						
	p o t	Funeral Director	Usual Residence of Decedent 10a. State 10b. County	IOc. City, Town or Loc	nation				10d. Inside City Limits						
	a-f st fied								1 Yes 2 XNo						
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The family and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		MD Queen Anne's	Millingtor	1 10f. Zip Code		10	ng. Citizen of What C							
		eral	309 Rings End Road		21651			SA	ountry:						
	tems tems	T.	11. Manital Status 12. Was Decedent Eve		/as Decedent of Hi	ispanic Origin? (Spe	ecify Yes or No-	14. Race - Am	nerican Indian,						
စ္က	fter d	by	1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 And If Yes, Give	0	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, Wh	ite, etc.						
21215-0036	ours a	ted	3 ∟ N Widowed 4 ∟ Divorced Year or Dates.					Specify: W	nite						
7	72 hc n "na Aedic	To Be Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occup: ind of work done o DNOT use retired)	ation Iu <i>ring</i> most of work	ing 1	6b. Kind of Busines	s Industry						
7	vithin jene. er tha the h		Elementary/Seconday (0-12) College (1-4 or 5+)	Homema				Own Home							
g	filed valued by all Hyg		17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, Ma	aiden Surname)							
<u> a</u>	ld be Menta arkec atic e		Edward Murdock			Margare	t Grimm								
Maryland	shou and is m		19a. Informant's Name/Relationship (Type, Print)	Late			•	City or Town, State, 2	' '						
e)	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to once.		Lanora Wilhelm - Daughter 20a. Method of Disposition					Mary1and							
Baltimore,			1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State	_	atory or other plac	e)		0c. Location - City of							
를	artme artme ortani injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Sign vure of Funeral Service Licensee						le, Maryland						
Ba	Dep Imp any onc		Newwood Miller					lfenbein .							
			23a. Part 1. Enter the disease, or complications that caused the reath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												
-4	hysician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death												
	Medical Examiner		resulting in death) Due to (or as a company)		3 / - 1/6 3				Lyeurs						
		Examiner	Sequentially list conditions, b.												
	ed sit		If any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury												
	ne law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Exa	that initiated events resulting in death) Last Due to (or as a consequence of):												
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876	ificate ng phy as th		IF FEMALE:		· <u>-</u> ·										
89 ×	requires that the death certific been signed by the attending I should be detached for use as		23b. Was decedent pregnant in the past 12 months?	🗌 Fetal death 3 🔲	Ectopic pregnanc	у			23d. Date of delivery						
Вох	e deal the at hed fo		1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at ti 9 ☐ Unknown 9 ☐ Unknown	me of death 5	Other (specify)			Month	Day Year						
ö	at th	h Ph	That it. Other significant conditions contributing to death but not resulting in the underlying cause given in Fact it.												
S,	uires t n sign ld be	ed by	Arterio Schrotie Cardio	2 10 No 3 1	Probably 4 🗆 Unknown										
ord	v requ	olete			utopsy findings available										
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<u>a</u>	sician: The law I s certificate has b lirector, page 2 s		25. Was case referred to medical examiner?		26. Pla	ace of Death (Check		INO I I I	es Z III NO						
Division of Vital Records, P.O.	hysic his ce Il direc		1 Yes 2 THO Hospital:	2 ER/Outpatient		4 L Nursing Ho	me 5 🗆 Residen	ce 6 Other (Spe	city) Hospice Itous						
	ling P n. After t unera	ate:	27. Manner of Death 1	28b. Time of injury	28c. Injury work	?	28d. Describe how	injury occurred							
<u> </u>	death death stor: A / the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	- At home, farm, stre		Yes 2 No	20% Location Charactered Number - Dural Parts Number								
Š	l or A after Direc	Š	4 Homicide determined building, etc. (et, factory, office		City or Town,	ion (Street and Number or Rural Route Number, r Town, State)							
_	one nospinal or Australiang Priysican. within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.												
			(Check only one) Check only one) Check one) Check only one) Check only one) Check one) Check one) Check one) Check one) Check one) Check one) Check one												
	Voirt Corr		29b. Signature and title of certifier	number			e signed (Month, Day, Year)								
9	10		9/8/10												
	Tm		30. Name and address of person who completed cause of dear 5 wan K. Ross, M.D. 5/L M. 31. Date filed (Month, DeSEP) 9 20 102. Registar's	th (Item 23a) (Type, Pr	rint)	11.	26 211	20							
	Stat	e	31. Date filed (Month, DeSEP 9 20 02. Regis far's	Signature	backer	riter TEAN	210	~ {)							
	Registra	r	SEP OF ZUID	we p. 1	7										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Month Lydia Anna Krivicke Sept. 5 12:15 Medical p 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bedford Court Assisted Living Silver Spring Montgomery Social Security Number 6. Sex 8. Date of Birth (Month, Day, Jan. 2, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours Min. 292-12-7126 86 Yrs. Director Jan. 1924 Ohio Usual Residence of Decedent show or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🄀 No Maryland Montgomery Silver Spring ō 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Examiner must be Funeral 3700 International Drive, #160B 23a 20906 hours after death with USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc ò þ 1 Never Married 2 Married 2X No Maryland 21215-0036 ☐ Yes If Yes, Give Year or Dates 1 Yes 2X No Specify. Specify: White "natural" Completed 3 - Widowed 4 - Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 Analyst Federal Government other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of 2 Alexander Krivicke traumatic Anne Kellert of and 2 should be of Health and Meritiem 27 is mark rother traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27104 Robert Wayne Loekle/Personal Rep. 5344 Old Plantation Circle, Winston Salem, NC Baltimore, 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖰 Burial 2 🗆 Cremation 3 🗆 Removal from State meadowridge Memorial Sept. 2010 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Park Signature of Funeral Service Licenses Francis de Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 503 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Cardiorespiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Due to (or as a consequence or) attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Chronic Hypertensive Heart Disease Due to (or as a consequence of) resulting in death) Last Physician/Medical Deep Vein Thrombosis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Year Pregnant at time of death Yes 2 K No g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Tunknown Completed page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) Assisted Living Hospital 1 Yes 2 KNO ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred $5 \square$ Pending injury ours after death. leral Director: Af filled In by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

15

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

31. Date filed (Month Da

30. Name and address of person who completed of Patricia Gomez, MD

se of death (Item 23a) (Type, Print)

egistrar's Signature

323

15245 Shady Grove Road, #130, Rockville, MD 20850

29d. Date signed (Month, Day, Year)

Sept. 7,

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2010 Sept. Golden Robert Kirk /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital Garrett Garrett Co. Memorial Oakland 8. Date of Birth (Month, Day, Year) 11/18/1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral X**XM 2□ F Months Days Hours Min. 85 235-22-5021 Director WV Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examinations to rother traumatic event, I'm Medical Examinations to see the provided at XXes 2□No Director Garrett Oakland MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21550 US 706 East Alder St. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. 1 ∐Yes 2 V No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes XXNo Specify Specify: white ģ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) coal miner mining 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Golden Kenneth Kirk Miggie Riley Kirk ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26707 PO Box 35, Bayard, WV., Ethel Simmons 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 09/17/2010 Morgantown, WV. Omega Crematory 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of a la Service Licensee ^{22. Name and Address of Facility} Arthur H. Wright Funeral Home 105 Highland Ave., Terra Alta, WV, 26764 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Soy513 **Physician** [Neymon, 2 60 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed? 1 Yes 2 KNo or Attending Physician: The Division of Vital 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nation 2 □ ER/Outpatient 3 □ DOA After this funeral dir Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director* A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of entifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) **SEP 1 7 2010**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Richard A. Porter DO., 311 N. Fourth St., Oakland, MD., 21550

H0064705

10-06747 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Homer Kamp State of Maryland / Department of Health and Mental Hygiene																
William Homer I		p 1- For State	St	ate c	of Marylar			nt of He <i>te of D</i> e		nd Men	ital Hy	giene		201	0 0000	
Physicia	an/	Registrar 1. Decedent's Nam	ne (First, Midd	e,Last)			Tunca	le oi De	aur		12	2. Date of De	Reg. No	201	3. Time of Death	
Medical Exami		William	Homer :	Kamp							- 1	Month Septemb	Dav	Year 2010	0610 hrs	
· · · · · · · · · · · · · · · · · · ·		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or L										c. County of Dea	th			
Formand.		1374 Chest 5. Social Security N			[7	Age (In yrs.	lost hirth		antsville		0.41.1	0.5		Garrett		
Funeral Director				6. Sex		Age (in yrs.		M	Inder 1 Ye		er 24Hrs. Min.	March	Sirth(MM	1926 o	irthplace (State or ign ountry) Maryland	
_		217-28-8844 1X M 2 F 84 Yrs. Morths Days Hours Min. March 21, 1926 Cour														
r any		10a. State 10b. County 10c. City, Town or Location							10d. Inside City Limits							
land f show	ō	MD	Garre	tt	Grantsvil		ille							1 Yes 2 X No		
Mary r 28a- red at	Director	10e. Street and Nu									_	tizen of What Co	untry?			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show a injury or other traumatic event, the Medical Examiner must be notified at once.											of and to disc. Plants					
eath w items	Funeral	1 Never Married 2 Married Armed Forces?					If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						10-	White, etc.	erican Indian, Black,	
after d	by Ft	3 X Widowed 4 Divorced If Yes, Give Year or Dates:					1 Yes 2 X No specify:							Specify: White		
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5-00 sd with other of	To Be C	12 17. Father's Name (First, Middle, Last)				18.Mother's Name				's Name (I	irst, Middle					
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		Lloyd Kamp					Bessie War					arnick	ick			
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, MD and 2 sho ealth and em 27 is		Sherry L 20a. Method of Dis		/Dai	ıghter	20b		4 Doll Disposition (_			ale, N		Location - City of	er Town State	
Ore ges 1. it of H :: If it		1 X Burial 2	Cremation	_	Removal from	State	cremator	y or other pla	ace)							
Baltimore, permit. Pages 1 ar Department of Her Important: If ite		4 Donation 5 21. Signature of Fu			ee	Tr	init	y Ceme	_						sville, MD	
Ba Pem Dep Imp		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.O. Box 275, Grantsville, MD 21536														
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		or condition resulting in death) Due to (or as a consequence of): b.														
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Box 68760, e death certificate be ex the attending physician be for use as the burial.	sician/Medi	IF FEMALE: 23b. Was decedent		e	23c. If yes, out		nancy 2	Fetal dea	ath 3	Ectopic	pregnanc	:v	23	ld. Date of delive Month	ry Day Year	
ox 6 ox cer ox cer	sicia	Pregnant at time of death 5 Other (Specify)														
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Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed											24a. Was			utopsy findings available	
Recol The law cate has	dmg			_								auto perf	ormed?	death?	completion of cause of	
tal Recting The certificate	0	25. Was case refer	red to medical						26.Plac	e of Death ((Check on		2	1 V	65 2 140	
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n of ding Ph		Manner of Death Natural			28a. Date of (Month, D. Sep 7, 20	Injury av,Year) IO	28b. Tid 0555 I	me of Injury		ury at Work	S	Bd. Describe ubject str		ury occurred / car		
Sion Attencer Transported Tran	icati	2 🗸 Accident	Inves	tigation	28a Place o					Yes 2		of Location	(Street o	and Number or P	ural Route Number, City	
Divis pital or At ours after d filled in by	Certification:	Suicide 6 Could not be determined (Specify) Major Road / High					or Town, State					State)	ge Road , Gran			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)														
To with	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									onth, Day, Year)					
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		30. Name and addre			•	,	, -									
Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month Secret) 2010 32. Registrar's Signature																
Regist			vet I	J 20	10	and o digitall	A.	par								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ()9 04^{Day} **Physician** Lori Kutzko Ann 20ÏÖ 4 Α М /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Caroline 1103 Cattail Commons Way Denton 8. Date of Birth (Month, Day, 03 05 5. Social Security Number . Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

D Δ **Funeral** ^{Year)} 1959 Days Hours Min Months 164-54-8508 1 □ M 2 🕱 F PA 51 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lolury or other traumatic event, the Madical Expression 1116 at 1116 at 1116 at 1116. 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location MD Caroline Denton 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21629 USA 1103 Cattail Commons Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black. White, etc 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cecelia Blanche Sarnacki Theodore Schmidt ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1103 Cattail Commons Way, Denton, MD 21629 Steven M. Kutzko / husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 X Removal from State Resurrection Cemetery 9/8/2010 |Moon Twp, Pennsylvania 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Moore Funeral Home, P.A., 12 S. Second St., Denton, MD21629 of Funeral Service Lice 00 Approximate Interval Between Onset and Death Since 2005 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ovarian cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed attending physician and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) the 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy certificate 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

Hospital or Attending Physician: The filled in by the funeral 24 hours after death Funeral Director: within 2 To the

> State Registrar

cal

3 Suicide

29a, Certifier

4 ☐ Homicide

29b. Signature and title of certifie

31. Date filed (Month Day, Year)

SEP

30. Name and address of p

GREGORY

165

14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
21 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

MA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ause of death (Item 23a) (Type, Print)

Registrar's Signatur

1630

and manner stated.

ZINGA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sept Bettie Sue Kugelmann 2010 6:00AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Caroline Nursing Home Caroline Denton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, April 5 1 M 2 X F Hours Min. 86 Oklahoma 1924 Director 443-20-0032 Yrs Usual Residence of Deceden iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. Count within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director DE Sussex Milford 1XXYes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 311 S. Walnut St 19963 US 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ♣ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White nan "natural", Medical Exar 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 2 should be filed within 72 n lith and Mental Hygiene.

127 is marked other than "r arked other than "r ar (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) REalty Bus. Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Y Nabb Jimmie P Sanders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a Theresa A Kugelmann 9235 Fox Meadow La., Easton, MD 21601 20a. Method of Disposition
1 ☐ Burial 2 🎖 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
1st State Crem. Ser Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 9-2-10 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rogers Funeralt Home Inc 301 Lakeview Ave. Milf anature of Fundamervice Licenses Lakeview Ave., Milford, DE 19963 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Pnysician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of). and I-transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Month Day the 9 Unknown P.O. ģ Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. signed be det 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate Yes 2 No Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After the 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 8 1 30 PM Physician/ William Michael Kurak Jr. Zolo Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner oastal lisbur Hospice at the WICOMICO 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **K** M 2 □ F 477-07-9863 Months Hours 1071171916 Minnesota **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Worcester Ocean City 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 13312 Nantucket St. 21842 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Race - American Indian. Black, White, etc. 1 X Yes 2 No If Yes, Give Navy Year or Dates. Completed by 1 Never Married 2 X Married 21215-0036 1 Yes 2 No Specify: white 3 🗌 Widowed 4 🗌 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Naval Air System Command Management Analyst Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sofia Wakusa William Michael Kurak Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3007 Pasture Ct., Surgar Land, TX 77479 William J. Kurak/son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Cheltenham Maryland Veterans Cemetery 1 🔀 Buriai 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 9/10/2010 Cheltenham, MD Signature of Funeral Service Licenses Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CESP 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final CEREBROVASCULAR Physician/ disease or condition resulting in death) ACCIDENT Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tranthat initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown the detached Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death,

To the Funeral Director: After this certificate has been signed by 1 completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2/ No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe Yes 2 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence HOSPICIZ မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certified 29d, Date signed (Month, Day, Year) MAM D0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Co Hu in 31. Date filed (Month) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Franklin Kirwan September 3:37 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 8246 Baptist Church Road Wicomico Mardela Springs 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Maryland 0771971946 219-44-1236 64 Director Usual Residence of Decedent 3a or 28a-f show t be notified at 10d Inside City Limits 10b. County 10c. City, Town or Location 10a, State within 72 hours after death with the Maryland Funeral Director 1 Yes 2 X No Maryland Wicomico Mardela Springs 10g. Citizen of What Country? 10e. Street and Number permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b. 8246 Baptist Church Road 21837 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 X Yes 2 □ No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white Navy Completed 3 X Widowed 4 Divorced Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) carpenter construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clinton Kirwan Ada Horner Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hellen Disharoon/companion 8246 Baptist Church Rd., Mardela Springs, MD21837 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Bivalve U.M. Church Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/10/2010 Bivalve, MD 21. Signature of Funeral Service Linesee Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or completions that caused shock, or heart failure. List only one cause on each line fions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Liver cancel Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any list of the cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to or as a consequence of): and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ျာ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) -mp IVA death (Item 23a) (Type, Print) Penisula Res. Occup. Health State Registrar

DIRECTOR AND LABOUR.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:470M September Allan Kenyon Little 06 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chevy Chase 3534 Woodbine Street Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 💹 M 2 🗆 F Days Min washington. Yrs. **Director** 213-48-4996 54 DC Usual Residence of Decedent 28a-f show 10b. County aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Medical Examiner must be notified 1 🗌 Yes 2 🗓 No Maryland Chevy Chase Montaomeru 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3534 Woodbine Street 20815 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or þ 1 X Never Married 2 Married 1 Yes 2 X No Specify: Completed 3 Divorced White. Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Private Engineer Technician permit. Page 1 and 2 should be filed in Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Llewellyn Little Maru Janet Kenuon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NW. #514, Washington, DC 20016 Quinn O'Connell. Ir. - Trustee 5100 Wisconsin Ave.. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Parklawn Mem. Park 09/13/2010 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M01024 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 0~ <u>|11800 New Hampshire Ave., Silver Spring,</u> MD 20904 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. 23a. Part 1. Enter the disease, co shock, or heart failure. List on Immediate Cause (Final Onset and Death Physician/ Adult Failure to Thrive disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence oi): ig physician and as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No for Day Year Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Depression 24a. Was an page 2 performed? 2 🗌 No Yes 2 🗓 No 1 Tes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 1 or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) Hospital: 1 🗌 Yes 2 🗶 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D37142 September 08, 2010 ess of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Coleman, 1355 Piccard Drive, Rockville, Maryland 20850 MD.

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Segistrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend I tem 21 per FH G907 9/27/10 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 11 2010 11:30 AM September Evalene Mae Leaf /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 18028 Par Three Drive Washington Hagerstown 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** 1 □ M 2X F Pennsylvania 12,1918 Director 220-58-3082 92 Feb. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Eventines must be notified at 1 ☐ Yes 2XXXVo Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 18028 Par Three Drive Funeral 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2**X** No Baltimore, Maryland 21215-0036 1 □Yes 2√XNo Specify. Specify: ģ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'n any injury or other traumatic event, Its Men Elementary/Secondary (0-12) College (1-4or 5+) 12 <u> Housewife</u> Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Irvin Bollinger Rhoda Elizabeth Reynolds ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14801 Bottom Road Williamsport, Maryland 217 ace of Disposition (Name of Date 20c. Location - City or Town, State 21795 Susan E. Wade - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem, Park Sept.16,2010 Williamsport, Maryland Signature of Funeral Service Licensee Craig N. Osborne per DVR Osborne Funeral Home, P.A. 425 S. Conococheague St.Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atrial tibrillation Physician months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Infarction myocardial Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed and Due to (or as a consequence of): burial-Box 68760 physician Physician/Medical the as attending properties for use as IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **X** No Month Day Year 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown þ care nas been signed page 2 should be defe Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, à 2 No 3 Probably 4 Unknown tension 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 No certificate I Division of Vital Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 Natural 5 Pending Injury within 24 hours are: ___ You the Funeral Director: Aff 1 ☐Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) or A 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Cisa tama 09-13-2010 D0066288 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

State

31. Date filed (Month, Day,

Year)

4

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	State RegistrarDecedent's Name (First, Middle,	, Last)		Cer	tificate of D	eatn		2. Date of De	Reg. No.	010	3. Time of D
n/ :al	GERALDINE	C. L	INGO					SEPT.	Jay .	2010	223
er	4a. Facility Name (if not institution,	. /	4. /		4b. City, Town, or	,		•		ounty of De	•
	MINSUM REGION 5. Social Security Number	6. Sex	7. Age (In yrs. Ia	st birthday)	If Under 1 Year	If Under		8. Date of Bir		1/20/1/0 9. B	lirthplace (State or I
	221-40-2899	1 □ M 2 X F	79	Yrs.	Months Days	Hours	Min.	SEP 17,	1930	SAL	ISBURY,
ŏ	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation						10d. Inside City
Director	DELAWARE SUSSI	EX COUNTY	MI MI	LLSBO	RO						1 🔀 Yes 2
	10e. Street and Number				10f. Zip Code					n of What C	4.07
Funeral	115 DELAWARE	AVENUE	edent Ever in U.S	13 V	19966 Vas Decedent of His	spanic Orio	gin? (Spe	ecify Yes or No-		ED ST	ATES
by F	1 Never Married 2 Marr	ied Armed Fo	orces? 2 X No	lf	Yes, specify Cubar	n, Mexican	, Puerto		14	Black, Wh	
	3 X Widowed 4 Divorced	If Yes, Giv Year or D			Yes 2 No	Specify:			Sp	ecify: W	HITE
Completed	(Specify only higher	7		(Give k	ent's Usual Occupa ind of work done do NOT use retired)		t of work	ing	I	of Busines	•
	Elementary/Seconday (0-12)	College (1			NER/OPERA	ATOR				SERVI	RINE SALE: CE
To Be	17. Father's Name (First, Middle, Le	ast) CAUFFIEI	L				er's Nam	e (First, Middle, LAN		rname)	
	19a. Informant's Name/Relationsh DALE LINGO III				g Address (Street a					at . Allering	Zip Code)
	20a. Method of Disposition			ace of Dispos	sition (Name of	1		Date			or Town, State
	1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)		Otato		VET . CEM		SEP	7,2010	MILL	SBORO	, DE 1996
	21. Signature of Improve Service Li	icensee/		- 1	Name and Address		*				
	2 a Part 1 Enter the disease or	om livatives that	MO 1			NERAL	HOM	E, PO I	30X 12	25 MIL	LSBORO, 1
	shock, or heart failure. List of	Differentiation to triat .		130 not ente	r the mode of dvino	such as	cardiac o	or respiratory ar	rest		Approximate
	Immediate Cause (Final	nly one buse on ea	ach line.	. Do not ente	r the mode of dying	, such as	cardiac d	or respiratory ar	rest,		Approximate Interval Betwee Onset and De
		_ a(or as a conseque	nom	(10	, such as		or respiratory ar	rest,		Interval Between
ı.	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to	Operation (or as a consequent of the consequent)	ence of): Heatu	(10	1		or respiratory ar	rest,		Interval Between
miner	Immediate Cause (Final disease or condition resulting in death)	_ a(Barci	ence of): Heatu	(10	1		Tune	rest,		Interval Between
_	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to b. Due to	Operation (or as a consequent of the consequent)	ence of): +estu ence of):	(10	1		Tune	erest,		Interval Between
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by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	a. Due to b. Due to c. Due to d. 23c. If yes, out 1 Live 4 Preg 9 Unkt	(or as a consequence of pregnar Birth 2 Fetal nant at time of drawn	ence of): ence of): ence of): ence of):	Ectopic pregnancy Other (specify)	ron on		Zune 23e. Did t	236 obacco use	Month contribute	Interval Between Onset and De Week Onset and De
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DH 10 State Registrar

DHMH 17 Rev 7/2009

parker

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SON PARTICOVICH MD 100 & CARR

31. Date filled Month, Day, Year)

SEP 0 9 2010

SEP 0 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 29940 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Meredith ourse 1200 September 3010 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Memoria Fastur toot Hospita 0 Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □X (Month, Day, Year) 04/09/1925 Country) Marvland Months Days Hours Min. **Director** 218-16-6798 85 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21620 414 High Street USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ₫ 1 ☐ Yes 2 XNo If Yes, Give 3altimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates Ellen meredith 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George O. Smith Ruth Hastings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Donna Hayman -</u> Daughter 414 High Street Chestertown, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) <u>Dorchester Memorial</u> 09/18/2010 Cambridge, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Fellows, Helfenbein & Newnam Buk Q Speer Road Chestertown, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, than y leading to him is diate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No led by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform 2 No this certificate 1 🗌 Yes Yes 2 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) D54488 MD 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bennett 50, MD, 219 5;

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

2010

Washington

Easton

MD 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Amend #1, 9-10-2010, per Dr., Health and Mental Hygiene Registrar Registrar 1. Decedent's Name (First, Middle, Last) Jean Juanita Mancino Manning 2. Date of Death Dav Month Year Physician Mancino September 4 2010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Valley Nursing Montgomer POTOMAL 6. Sex 8. Date of Birth (Month, Day, July 9, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
____ 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Min. Months 1 □ M 2 🔼 F 304-22-8153 9 1Yrs Texas Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show 1 AYes 2 No Director MD Potomac Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1492 Selworthy Road 20854 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Yes 2 ☐XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify Specify: 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within wental Hygiene.
127 Is marked other than "ry traumatic even* Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leander Swartzlander Berta Green 2 permit. Pages 1 and 2 should Department of Health and MA Important; If item 27 Is mark any injury or other traumati once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debrah Van Alstyne, Daughter 1492 Selworthy Rd. Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/9/2010 All Souls Cemetery Germantown, Maryland 4 □ Donation 5 □ Other (Specify) M01463 Simple Tribute 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1040 Rockville Pike, Rockville, MD 20852 Approximate Interval Between Onset and Death 23a. Part 1. Enter the diser e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or earl failr re. List only one cause on each line. Immediate Couse Final disease or conflion Si Se **Physician** 2 week disease or confine resulting in death) /Medical Due to (or as a consequence of): Examiner 6 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death.
Funeral Director; After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No ed by the a 9 Unknown signed I Part II. Other significant, conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 140 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Themas, Chap

State Registrar

Garren

30. Name and address of person who concleted cause of death (Item 23a) (Type, Print)

MACY HAYNOS, CRIP 10110

1 0 2010

Year)

crnp 32. Registrar's Signature 10110 Molecular Drive Rockville ML# 206

			For	State	e of Ma	aryland /	-				nd Me	ental Hyg	giene	00:	0 0	
			State Registrar				Cer	tificate	of De	eath			Reg. No.	211	11 2	9942
	Physicia	n/	Decedent's Name (First, Middle,	Last) Mar ⁼	2-1							Date of Dea Month	th Day	Year		e of Death
	Medic	al	Ellen									septem?	K.T		-	I IVI
	Examin	er	4a. Facility Name (if not institution,		number)			4b. City, To		Llsto			4c. U	4c. County of Death Baltimore		
	Funeral		Seasons Hospic 5. Social Security Number	6. Sex	7. Age	(In yrs. last bi	irthday)	If Under 1	Year	If Under 2	4 Hrs.	8. Date of Birth	1	9. E	Birthplace (Sta	te or Foreign
	Director		578-42-8270	1 □ M 2 X	F	87	Yrs.	Months	Days	Hours	Min.	8/11/	1923		Country) N	Y
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0500-6121	e filed within 72 hours after death with the Maryland tral Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Deceden (Specify only highes	t grade comple			(Give I	lent's Usual kind of work O NOT use r	done dui	ion ring most d	of working	g	16b. Kind	of Busines	ss Industry	1
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Mary	should and Me is mar raumati		19a. Informant's Name/Relationsh			19	9b. Mailin	ng Address (Street an	d Number	or Rural	Route Number	City or To	wn, State,	Zip Code)	
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saitimore,	- to ± 0		20a. Method of Disposition 1 A Burial 2 Cremation	3 🗌 Removal f	rom State	ceme	tery, cren	sition (Name natory or oth	ner place)			ate		-	or Town, Stat	
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g	permit. Page Department of Important: If any injury or once.	ļ. J	21. Signature of Funeral Service Li	Censee	1	M00012	4	. Name and	address	of Facility	oia P	ike E	llico	tt Ci	ty, MD	21043
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	Medical		disease or condition resulting in death)	a. Due	to (or as a	consequence	e of):	11) 						
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VII.	ysicia s cert direct	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	1 🔲 Inpatie	ent 2 🗆 ER/	Outpatier	nt 3 🗆 DO	Other	: 4 🗆 Nui	rsing Hor	ne 5 🗆 Resid	dence 6	Other (Sp	pecify) Hos	pice
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0	eath. or: Af the fu	ifica	2 Accident Investig	ation				М		'es 2 🗆						
Division of Vital Records,	or Att	Certificate:	4 Homicide determine	28e. P	lace of Inju uilding, etc	ry - At home, . (Specify)	farm, str	eet, factory,	office		2	28f. Location (S City or Tou		Number or	Rural Route N	lumber,
ב	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a, Certifier 1 Certifying	Physician: To t	he best of	my knowledg	e, d eath	occured at t	he time, o	date and p	olace, and	d due to the ca	use(s) and	manner as	stated.	
	n 24 h	Med	(Check 2 Medical E only one) 3 Certifying	Murca Draction	nor Totho	heet of my kno	appolyer	death occur	ed at the	time date	and place	and due to th	e cause(s) :	and manner	as stated.	
	Vithi To th		29b. Signature and title of certifier			_		29c.	License i	number	, -		29d. Date	signed (Mo	onth, Day, Yea	7)
			> 115 Kajapas	ne M.D					DOO"	574	65		9	18/	-	. 0
	8		29b. Signature and title of certifier 15 Ruyuf (Mark) 30. Name and address of person of the second	who completed	cause of de	Z835	a) (Type, F	Th t	1 - V	- 203,	- 2	Baltim	dre,	MD	,212	7
	Sta Registra	te ar	31. Date filed (Month, Day, Year)	2010	32. Pegistra	ur's Signature	4	arke								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September Day 5, 2 **Ö**T 0 Physician/ 7:00 Рм Patricia Ann Middlemas Michael Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Woodsboro 9013 Geisbert Road 9. Birthplace (State or Foreign Country) Chile If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5, Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F Months Days Hours July 30, 1931 79 122-26-6265 Director Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland Director 1 Yes 2 XX No Woodsboro Maryland | Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 21798 9013 Geisbert Road and Mental Hygiene.
is marked other than "natural", or items;
raumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. by 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ₩Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Journalism Editorial Researcher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helena Theresa Shay Robert Steele Middlemas permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9013 Geisbert Rd., Woodsboro, MD 21798 R. Steele Michael / Son Baltimore, Sept. 7, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Resthaven Crematory Frederick, Maryland 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of the strvice Lensee 22. Name and Address of Facility Kesthaven Funeral Services, Skkot Cody P.A. MD 21701 M 01237 Frederick, 9501 Catoctin Mountain Hwy. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line.

Immediate Cause (Final disease or Indition Chronic obstructive pulmonary disease Interval Between Onset and Death Physician Chronic obstructive pulmonary disease - Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending phys for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month in the past 12 months? Day Pregnant at time of death Yes 2 X No signed by the a d be detached f 1 ☐ Yes 2 ☑ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1X Yes 2 No 3 Probably 4 Unknown Osteoporosis, Osteoarthritis Division of Vital Records, Completed peen 24b. Were autopsy findings available 24a. Was an Congestive heart failure prior to completion of cause of death? page 2 s autopsy has performed' 1 🗌 Yes 2 🗌 No certificate Yes 2 K No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 & Residence 6 Other (Specify) Hospital: nours after death.

neral Director: After this conditions in by the funeral director. 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 IDOA ျှ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27, Manner of Death 28d. Describe how injury occurred Certificate: X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C completed filled Hospital Medical Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and fitte of 29c. License numbe 29d. Date signed (Month, Day, Year) September 7, 2010 D 35183

DHMH 17 Rev 7/2009

State Registrar

20

32. Regist ar's Signature

300 West 9th Street, Frederick, MD 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ali J. Afrookteh, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

			1 - State of Maryland / Dep State Registrar Ce	ertificate of D		ai Hygien Reg. N	0010	29944
	Physicia	_	1. Decedent's Name (First, Middle, Last) MIRIAM MURILLO				ray Year	3. Time of Death 7:54P M
	/Medic Examin	-	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lanham	ocation of Death	4	c. County of Death	h
	Funeral Director		Doctors Community Hospital 5. Social Security Number 149-74-1337 6. Sex 1 M 2 M 2 M 7. Age (In yrs. last birthday 7. Yrs.) If Under 1 Year	Hours Min. 8. Da	te of Birth conth, Day, Yea		nplace (State or Foreign untry) aragua
	show at at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	Location				10d. Inside City Limits 1 XYes 2 ☐ No
	r 28a-f s notifie	Director	Maryland Prince Georges Greenbel 10e. Street and Number	10f. Zip Code		10g. 0	Citizen of What Co	
	ath with		6502 Springcrest Dr.	20770			.S.A.	il and to disc
30	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	3.7	panic Origin? (Specify Yo , Mexican, Puerto Rican, Specify: Nicarac		14. Race - Ame Black, White Specify: Wh:	e, etc.
12-N036	in 72 hour "natural ledical Ex	Completed to	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv.	edent's Usual Occupat re kind of work done du DO NOT use retired)	ion	16b.	Kind of Business/	
717	d within 'giene. er than " the Mec	mo:	Elementary/Secondary (0-12) College (1-4or 5+) 12 6 Tea	acher				
	be filed ntal Hygi ed other event, tl	Be	17. Father's Name (First, Middle, Last) Francisco Castellon		8. Mother's Name (First Rosa Carmer		,	
Maryland	s 1 and 2 should f Health and Men frem 27 is marke other traumatic	으	19a. Informant's Name/Relationship (Type. Print) 19b. Mai	iling Address (Street an	ad Number or Rural Rougest Dr. Gree	te Number, City	y or Town, State, 2	
	s 1 and f Health item 27 other tr		20a. Method of Disposition 20b. Place of Disposition	position (Name of rematory or other place,			Location - City or	
	Pages ment of I ant; If its ury or o				Park 9/13/2			
Baltimore,	permit. Pag Department Important; any Injury once.		Pulled Dend-		olis Rd. Lar	nham, M	Funeral D 20706	Home
Ċ	death certificate be executed Medical Examiner dior use as the burial-transit	edical Examiner	23a. Parf 1. Enter the dispase, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23a. Parf 1. Enter the dispase, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. AMOSCUO Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	tic hear erolemia Ilitus	t discase			Interval Between Onset and Death
O. Box o		Physician/Me		B Ectopic pregnancy Discrete (Specify)			23d. Date of de Month	livery Day Year
7	luires that the de n signed by the a lid be detached f	b	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giver	n in Part I. 2	23e. Did tobacc		o the cause of death?
I Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed				24a. Was an autopsy performed X Yes 2□	? prior to death?	utopsy findings available completion of cause of
VITAI H	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Othor	26. Place of Death (Che			
on or	ding Phys h. After this funeral di	ion: To	27. Manner of Death 1 Natural 5 □ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time Injury	e of 28c. Injury Work	4 Nursing Home	5 Hesidence		эспу)
DIVISION	I or Atten after deat Director;	Certification:	2	street, factory, office		ocation (Street City or Town, St		ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation in my on	inion death occurred at	the time date	and place, and du	e to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	29c. License	number	29d.	Date signed (Mon	th, Day, Year)
F			O Name and address of pages who completed area of death (them 2001) To	D (g	1927		09/08/	2010
7	Sta	ate-	29b. Signature and title of certifier Dumble Carbulate 30. Name and address of person who completed cause of death (Item 23a) (Typ Elena M. Castro Doctors Hos 31. Date filed (Month, Day, Year) SEP 1 0 2010	pta/8/12	8 Goodlyc,	K Rd.	Lanham	nd
	Sta Regist		SEP 1 0 2010 Sever S. Sack	,				

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	For State Registrar				artment of I tificate of I			Reg. No. 20	0 29915
ian/ lical	1. Decedent's Name (First, Middle, L Jack	Lauren M	YERS				2. Date of Dea Month Septemb		3. Time of Death 255 A M
iner	4a. Facility Name (if not institution, g 8815 Boulder Hil			•	4b. City, Town, o Laurel	r Location of Deat	n	4c. County of De Howard	eath
al or	5. Social Security Number 217-32-6160 Usual Residence of Decedent	. Sex 1 🙀 M 2 □ F	e (In yrs. la: 74	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			Birthplace (State or Foreign Country) aryland
Director	10a. State 10b. County Maryland Washin	gton		Town or Loc				10d. Inside City Limits 1 Yes 2 □ No	
Funeral Di	10e. Street and Number 55 East Washing		Apt		10f. Zip Code 2174			10g. Citizen of What U.S.A.	Country?
	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 4 If Yes, Give Year or Dates.		If		lispanic Origin? (S) an, Mexican, Puert Specify:		Black, W	merican Indian, hite, etc. hite
Completed by	15. Decedent's (Specify only highest Elementary/Seconday (0-12)		+)	(Give k life. DC	ent's Usual Occup ind of work done of NOT use retired) Superii	during most of wor	king	16b. Kind of Busines	ss Industry contractor
To Be	17. Father's Name (First, Middle, Las unkn	•	!				me (First, Middle, Ethel	Maiden Surname) Myers	-
	19a. Informant's Name/Relationship Kelli Myers – da: 20a. Method of Disposition		Loo. B	8815	Boulder	and Number or Ru Hill Pla	ice, Lau	r, City or Town, State, rel, Maryl	and 20723
olice.	1 Burial 2 Cremation 3 4 Donation 5 Other (Special Signature of Funeral Service Lipe)	ecify)	Hag	erstow	sition (Name of patory or other place of Cremat		ember 3, 2010		n, Maryland
5	21. Signature of Funeral Service Lib	e de			Name and Addre			Funeral Hogerstown, l	ome Maryland 2174
n/ al er	23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.		nel	Cel	,	g, such as cardiac		rest,	Approximate Interval Between Onset and Death
dical Examiner	if any, leading to immediate cause. E. Lar Undership Cause (Disease or linjury that initiated events resulting in death) Last	C. Due to (or as a							
Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 4 Pregnant at 9 Unknown	2 🗌 Fetal	death 3	Ectopic pregnand Other (specify)	ру		23d. Date of Month	delivery Day Year
ed by Pł	Part II. Other significant conditions	s contributing to death b	ut not resu	ulting in the ur	nderlying cause gi	ven in Part I.	23e. Did to		e to the cause of death? Probably 4 🗆 Unknown
Completed by							24a. Was autop perfo 1 Yes	osy prior to prior to death	autopsy findings available to completion of cause of 1? Yes 2 □ No
Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:			Oth	lace of Death (Che			daughters
icate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	28a. Date of injur (Month, Day	у [ER/Outpatien 28b. Time of injury	28c. Injur	4 ∐ Nursing F v at		dence 6 Other (Sp low injury occurred	pecify) MidCace
al Certificate:	3 Suicide 6 Could no 4 Homicide determine	ed 28e. Place of Inju building, etc	. (Specify)				City or Tow		
Medical	(Check 2 L Medical Exa	hysician: To the best of a aminer: On the basis of ex area frectioner To the	camination	and/or investi	gation, in my opinio	on, death occurred ethne sate and pl	at the time, date a	and place, and due to the CSUB (s) and 112 me.	ne cause(s) and manner stated
Σ					29c. License	e number		29d. Date signed (Mo	rruri, Day, Year)
Σ	29b. Signature and title of certifier	1 Qualin	1	mo	041	667		9.13	. 16

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 30 per DVR G90/2/10 dk

State of Maryland / Department of Health and Mental Hygiene

Cortificate of Death For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER[™]7, 2010 Physician/ VERNELL JACQUELINE WILLIAMS MILLER 11:43 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In yrs, last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🛶 F FEBRUARY 15, 1946 GEORGIA Director 011-34-4692 64 Yrs Usual Residence of Decedent show Z7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MARYLAND 1X Yes 2 ☐ No PRINCE GEORGES ACCOKEEK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20607 UNITED STATES 18108 NORTH BRADSHAW COURT 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Armed Forces?
1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12)
12TH GRADE College (1-4 or 5+) SUP. MIL PERS MGT SPECIALIST FEDERAL GOVERNMENT permit. Page 1 and 2 should be filed with Department of Health and Mental Health and Mental Health and Jane any injury or other any injury or other space. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ ERNESTINE EVANS WILLIAMS FREDDIE LEE WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 N SANTA ROSA #1026, SAN ANTONIO, TEXAS ANGELA COURSE / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) MARYLAND VETERANS CEMETERY 09/15/2010 CHELTENHAM. MARYLAND 4 Donation 5 Other (Specify) 21. Landia C. THORNION JOHNSON MO0583 THORNTON FUNERAL HOME, 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ACUTE STROKE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner NON ST ELEVATION MYOCARDIAL INFARCTION Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a sthe burial-t Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death been signed by the should be detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ ALCOHOLISM 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? TYPE II DIABETES MELLITUS 24a. Was an this certificate has ral director, page 2 autopsy performed' 1 Yes 2X No XYes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **X** No Hospital Other: 1 Tes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident Director: A Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 41752 SEPTEMBER 7, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 1500 Forest Glen Borad, Silver Spring MD 20910 Dr Bergit Schoellmann, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7:21 PM Gary Lee Morris September 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 X M 2 □ F 219-66-2124 Director 54 25, 1955 Maryland Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Exal, item roust be retified at 1 XYes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, Its Medical Exal, its 1, ust but or 11 West Baltimore Street Apt.615 Funeral 21740 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 <u>~</u> If Yes, Give Year or Dates: 12-23-74 1 ☐ Yes 2 🛣 No Specify Specify: 3 Widowed 4 NDivorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Commercial Hauling 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Wilbur Lee Morris Mina Azalea Sweeney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bradley D. Morris (Brother) 636 Guilford Avenue Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rocky Gap State Vet. Cem. 9-14-10 Flintstone, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licens 22. Name and Address of Facility Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 1 Day Acute Renal Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Years Sequentially list conditions, and the light cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to lor as a consequence of The law requires that the death certificate be executed Chronic Obstructive Pulmonary Disease Years physician and the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 4 Pregnant at time of death P.O. | 1 □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 X Yes 2 No 3 Probably 4 Unknown s peen si should l Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? /es 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

3H-1+1

Registrar

Stephen Kotch MD E. Antietam St. Hagerstown, MD 21740 31. Date filed (Month, Day, Year)

SEP 1 3 32. Registrar's Signature

dress of person who completed cause of death (Item 23a) (Type, Print)

ome

29b. Signature and

29c. License number

00056965

29d. Date signed (Month, Day, Year) September 10, 2010

	1 - State Registrar			-	Ce	ertificate of	Death			Reg. No	2010	2994	8
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DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed cause of decade RAMASWAMY PARTHASARATHY, M.D. VAMC, 50

31. Date filed (Month, Day, Year)

32. Registrary Signature

33. Registrary Signature 30. Name and address of person who completed cause of death (Item 234) (Type, Print)

RAMASWAMY PARTHASARATHY, M.D. VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688

#0101055005

SEPTEMBER 8, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ P Jack Orlando Mills Medical Facility Name (if not institution, give street and number Jown, or Location of Death Examiner 4c. County of Death castal alisbur DICE at WICOMIC 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 385-03-9683 1 🛛 M 2 🗆 F Months Hours Min. 0271671922 MTCWigan 88 Director Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1109 S. Schumaker Dr., Apt. C8 21804 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married X Yes 2 🗆 1 Yes 2 No Specify: If Yes, Give Navy Specify: white 3 X Widowed 4 Divorced Completed Year or Dates. event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Naval Pilot U.S. Navy Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Nora Edna Curtiss Charles William Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 425 Monticello Ave., Salisbury, MD 21801 Andrea M. Coulson/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 9/7/2010 Salisbury, MD 2H01T18Way ess Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) years Medical Due to (or as a consequence of) Examiner Sequentially list conditions. il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, ed by the attending physician and detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a, Was an has ; page 2 s autopsy performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \bowtie Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🗷 Natural work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 9 11 29505 09 -0.5 Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.; GREGORIO M. BELLOSO. 5302 CHINABERRY DR., SALISBURY, MD ZIBOI 31. Date filed (Month, Day, Year) State SEP 0 Registrar

DHMH 17 Rev 7/2009

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death State of Maryland / Department of Health and Mental Hygiene Certificate of Death
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Dowel McMichael 2. Date of Death September 4 2010 1155 M
- septe	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death
No.	Funeral Director		5. Social Security Number 427-56-5546 6. Sex 7. Age (in yrs. last birthday) 1 M 2 F 77 Yrs. 7. Age (in yrs. last birthday) 1 Months 1 Days 1 Months 1 Mon
	laryland 3a-f show ified at	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Wicomico Salisbury 1 💆 Yes 2 🗆 No
	with the M s 23a or 28 ust be not	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1305 Lexington St. 21804 USA
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "hatural", or items 23a or 28a-f show amportant: If item 27 is marked other than "hatural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant in the Medical Examiner must be notified at once.	by	11. Marital Status 1
Baltimore, Maryland 21215-0036	ithin 72 hour iene. r than "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) \$\$ \$teel worker\$ 16b. Kind of Business Industry 16b. Kind of Business Industry
land 2	d be filed w Mental Hygi arked othe itic event,	To Be	17. Father's Name (First, Middle, Last) Zanny E. McMichael 18. Mother's Name (First, Middle, Maiden Surname) Essie Flowers
, Mar	nd 2 shouli ealth and h m 27 is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1305 Lexington St., Salisbury, MD 21804
timore	. Page 1 a tment of H tant: If ite jury or oth		20a. Method of Disposition 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 🗀 Donation 5 🗀 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Stephens Cemetery 9/10/2010 20c. Location - City or Town, State Date 20c. Location - City or Town, State Delmar, DE
Ball	permit Depar Impor any in		21. Signature of Fundral Service Licensee 22HS1990WadgesFUFField al Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804
	Physician/ Medical Examiner	er	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
09	ate be executed hysician and the burial-transit	dical Examiner	Cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last C. ALL Myself Last Due to (or as a consequence of): d.
). Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
ds, P.O.	quires that en signed k	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 (C) Unknown
Recor	: The law re cate has be ; page 2 sh	Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
f Vital	Physician this certifi ral director	: To Be	25. Was case referred to medical examiner?
Division of Vital Records,	or Attending s after death. I Director: After d in by the fune	Certificate:	28a. Date of Injury Matther of Death 28a. Date of Injury 28b. 1 lime of injury at work? 28d. Describe how injury occurred 28d.
	the Hospit nin 24 hours the Funera npleted fille	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	P Military Co.		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)
	5 m		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Market Green Treath 106 Mildord Street 5-th Gost Selishangt
H	Stat Registra		31. Date filed (Month, Day, Year) SEP 0 9 2010 32. Fegistrar's Signature SEP 0 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September Physician/ Edward Wingate 0650 M 2010 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Easton Talbot Memoria 5. Social Security Numbe 1 Year If Under 24 Hrs. Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland . Age (In yrs. last birthday Funeral 8. Date of Birth 1 🖳 M 2 🗆 F Months (Month, Day, 216-12-1768 Director 89 eptember Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Marvland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21629 25971 Shore Highway United States of America · death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕱 No Specify Specify: Caucasian Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) 11 HS Grad. College (1-4 or 5+) Farmer/Auto Mechanic Farming/Auto repair permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked any injury or are. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edna Elizabeth Vickery Wingate Nea1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11626 Double Fork Road, Greenwood, Delaware Judy Morris Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Concord Cemetery 9/3/2010 Federalsburg, Maryland . Sig f Funeral Service Lic 22. Name and Address of Facility Moore Funeral Home, P.A. South Second Street, Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) onjestive Medical Due o or as a consequence of) Examiner Dreumphia Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ue to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ementic and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2. autopsy perform death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2A No 1 Tyes 1

Inpatient 2 □ ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Mann.

Edward

Registrar's Signa

2160

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Alice O'Neill 8:30 Fav Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death isbu om 7. Age (In yrs. last birthday) If Under 24 Min If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 219-49-8123 1 □ M 2**½** F 10/14/1946 Director Marvland Usual Residence of Decedent 28a-f show 벎 Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 🗌 Yes 2 🎦 No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral , or items 23a 806 Crossbow Court 21804 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 X Married 1 Yes 2 X No Specify. Specify: White 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 shound bental Hygiene.
Health and Mental Hygiene. Coastal Elementary/Seconday (0-12) College (1-4 or 5+) Hospice socialwork Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be t Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e Calvin Handy Hadder Ryda Jarvis 19a. Informant's Name/Relationship (Type, Print) o. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 806 Crossbow Ct , Salisbury , MD 21804 Gerald F. O'Neill/spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sunset Memorial Park 20a, Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 , Removal from State 9/11/2010 Berlin, MD nation 5 D Other (Specify) e of Fundral Sen Thornway Fufferal Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ SMALL BOWILL disease or condition resulting in death) ADBNOCARCINDUM TIC Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 Tyes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) 2/1 No 1 Tes HOSPICA 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending 1 Tes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

6 Hayou

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32. Registrar's Signature

	Exa	mine
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	State of Maryland / Department of Health a 1- State Registrar Certificate of Death	0010 000
	Registrar 1. Decedent's Name (First, Middle, Last)	Reg. No. 2 3 Time of Death
cian lical	JAMES PAYNE / JR.	AUGUST 31 2010 4:29 P
iner	4a. Facility Name (If not institution, give street and number) FORT WASHINGTON HOSPITAL 4b. City, Town, or Location of FORT WASHING	FTON PRINCE GEORGE'S
l r	5. Social Security Number 578-48-2113 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year 1 Months Days Hours	24 Hrs. Min. NOV. 28 1936 Sirth Carolina (State or Foreight Morth, Day, Year) NORTH CAROLINA
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Director	MD PRINCE GEORGE"S FORT WASHINGTON	1 X Yes 2 □ No
	10e. Street and Number 10f. Zip Code 306 EAST TANTALLON DRIVE 20744	10g. Citizen of What Country? USA
Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Forces? 13. Was Decedent of Hispanic Original Free Specify Cuban, Mexican	
þ	1 Never Married 2 Married 1 Yes, Secure Cubait, Mexican 1 Yes, Specify Cubait, Mexican 1 Yes, Specify Cubait, Mexican 1 Yes, Specify Cubait, Mexican 1 Yes, Specify Cubait, Mexican 1 Yes, Specify Cubait, Mexican 1 Yes, Specify Cubait, Mexican	n, Puerto Rican, etc.) Black, White, etc. Specify: BLACK
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)	t of working 16b. Kind of Business/Industry
Com	10TH SPECIAL POLICE	PRIVATE
Be	TANCE OF THE PARTY	r's Name (First, Middle, Maiden Surname)
P		er or Rural Route Number, City or Town, State, Zip Code) 2074
	TANGA R. PAYNE/DGT. 306 EAST TANTALLO	N DRIVE FT. WASHINGTON, MARYLAN
	20a. Method of Disposition 1	Date 20c. Location - City or Town, State 9/7/2010 SUITLAND, MARYLAND
	21. Signature of Funeral Service Livensee 22. Name and Address of Facility 7474 LANDOVER R	y J. B. JENKINS FUNERAL HOMĒ OAD LANDOVER,MARYLAND 20785
edical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ser uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	cardiac or respiratory arrest, Approximate Interval Between Onset and Death
hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	23d. Date of delivery Month Day Year
by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknow
Completed		24a. Was an autopsy findings availal prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 X No
Be	examiner?	e of Death (Check only one)
Certification: To	27. Magner of De th 28a. Date of Injury 28b. Time of Injury at Work? 29c. Injury at Work? 29c. Injury at Work? 29c. Injury at Work? 29c. Injury at Work?	
	4 Homicide determined building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
edical	29a. Certifier (Check only one) 1 / Certifying Physician: To the best of my knowledge, death occurred at the time, date an examination and/or investigation, in my opinion, dea and manner stated.	
Σ	29b. Signature and title of certifier 29c. License number > 0054	733 29d. Date signed (Month, Day, Year)
state strar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HENGAMEH N. MESBAHI M.D. 1711 LIVINGSTON ROAD FT. 31. Date filed (Month, Day, Year) SEP 10 2010 32. Register's Signature	WASHINGTON, MARYLAND 20744

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dav Month Miriam Marietta Plantz September 2010 3:05 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 706 Pine Street La Plata Charles 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) anuary 23,1919 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Months Hours Director 192-14-5147 91 January Usual Residence of Decedent or 28a-f shov 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Charles La Plata 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 706 Pine Street 20646 USA death \ 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: white "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ferman Myers Mabel Bentz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie Sullivan/Daughter 11480 Sullivan Lane, Charlotte Hall, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Trinity Memorial Gar. 1 X Burial 2 Cremation 3 Removal from State 9/10/2010 Waldorf, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses M00945 22. AREHART ECHOLS FUNERAL HOME, P.A. au Mary's Ave La Plata MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final glur Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Mahznan Examiner Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and ated filled in by the Innerial director, page 2 should be detached for use as the burial-transit ated filled in by the funerial director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ Pregnant at time of death Month Day Year cate has been signed by the page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2X No Other: Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify, . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Plactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

BB7 State

DHMH 17 Rev 7/2009

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Larry Jenkins, M.D. P.O. Box 2665, La Plata, MD

00033426

September 7, 2010

Commerce Commer				For State Registrar	State	of Marylar	_	artment of H		and N	/lental Hy	giene Reg. No.2 (010	299	955
Subtributed Board Supplies the Courty of Supplies Supplie		Physicia	an/			nsev					Month	ath		3. Time of	Death
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Total State Total State		Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	.,,	If Under 1 Year	If Under		8. Date of Bir	th	9. Birth	place (State o	r Foreign
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All Date of Date Da		the had a or 2		10e. Street and Number				10f. Zip Code				10g. Citizen o	f What Cou	ntry?	
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22 Seption 1 Septiment 1 Septiment 2 Sep		Page Page ment ant: I		1 ☐ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other	n 3 □ Removal fro (Specify)	m State Ft				9/10	7/2010	Brentw	ood,	Maryla	nd
22 Seption 1 Septiment 1 Septiment 2 Sep	,	ermit.		21. Signature of Funeral Service	Licensee		3 22	. Name and Addres	s of Facility	y S	imple T				
Physician Medical Examiner Program Progra		<u> </u>		222 5-11 5-12								· · · · · · · · · · · · · · · · · · ·	D 208		
Securitary in conditions Securitary in condi	^	· · · · ·		shock, of fleart faflure. Lis	t only one cause on	each line.	n. Do not ente	r the mode of dying	g, such as	cardiac c	r respiratory ar	rest,		Interval Bety	veen
Sequentially list conditions, if any, leading to somewhat the control of the cont	7	Medical		disease or andition resulting in death)			ience of):						-		
Second Content Content	8	Examiner	L	Sequentially list conditions	b _Chr	onic Lym	phocyt	ic Leuken	13						
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Section Company Comp	7	red nsit	mine	Cause (Disease or injury	oue to (or as a con	sequence or):						
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27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury		ate ha						00 Pt /	1 🗌 Yes	2 No		2 🗌 No
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	5	sician certific directo	8	examiner?	Hospital: 1 Minpatient	2 ER/Outpatie	nt 3 DOA Oth	or:			Other (Specif	'y)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		ig rny ter this					Worl	₹?	28d. Describe	how injury o	occurred	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1210	death. tor: Af / the f.	icati	2 Accident investigation 3 Suicide 6 Could not b		At home, farm, st		Yes 2 No	28f. Location	Street and i	Number or Rur	al Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	<u></u>	s after Direction by	Sertif	4 Homicide determined	building, etc. (Sp	ecify)			City or Tov	vn, State)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		Tospita 4 hours -unera (ely fille	ical ((check only 2 Medical Example 12 Medical Example 2 Medical Example	niner: On the basis of exam							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	-	o the l	Med		and manner stated.					29d. Date s	signed (Month,	Day, Year)
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12 +1 VB Vectri vi. Dati - Vil				30. Name and address of person who	completed cause of death	(Item 23a) (Type	, Print)	61	00 North We	lfe St	Raltimo	re MD 21287
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			For State	of Marylan		artment of H		Mental Hy	giene 2 0 1	0 20057
			Registrar 1. Decedent's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·	Cer	tificate of L	eatn ————	2. Date of D	Reg. No.C. U	0 23331
	Physicia		Barbara Frances	Rice				Month Septe	Day Yea	3. Time of Death 2:15 p. M
	Medic Examin		4a. Facility Name (if not institution, give street and nu			4b. City, Town, or	Location of Deat	-	4c. County of D	
			Northampton Manor Heal	th Care	Ctr.	Fr	ederick		Freder	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			Birthplace (State or Foreign
	Director		Usual Residence of Decedent	10	Yrs.			10/17	71939 Pe	nnsylvania
	and show	ō	10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
	Maryl 28a-f xtifiec	rect	Maryland Frederick			Ijamsville				1 🗌 Yes 2 🏿 No
	a or 2	iQ le	10e. Street and Number	•		10f. Zip Code			10g. Citizen of What	
	th witl ms 23 must	Funeral Director	2324 Persimmon Drive				1754		United State	s of America
	r deal or iter niner		Armed F	cedent Ever in U.S forces? s 2 🛣 No		Vas Decedent of His Yes, specify Cubar	spanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc.
036	s afte ral", c Exam	ed by	3 ☐ Widowed 4 ☐ Divorced If Yes, G	ive	1	☐ Yes 2 🔀 No	Specify:		Specify:	White
2-0	hour 'natu	Completed	15. Decedent's Education (Specify only highest grade complete			lent's Usual Occupa kind of work done di		rking	16b. Kind of Busine	ss Industry
2	hin 72 ne. than '	lmo.		(1-4 or 5+)	life. Do	ind of work done di O NOT use retired) istrative A	-	Kirig	F-1	
Maryland 21215-0036	ed wit Lygie ther I nt, th	BeC	17. Father's Name (First, Middle, Last)		ACHETI	ISCIACIVE A		/F**	Education	
ano	be file ental I ked o c eve	일	Francis Szymanski					me (<i>First, Middle</i> Rpella	, Maiden Surname)	
ary	nould nd M s mar		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	a Address (Street a			er, City or Town, State,	Zio Codel
Σ̈́	d2sh aaltha ra27ie ertra		William F. Rice / Husband			•			Maryland 2175	
ore	of He of He if item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from	20b. P	lace of Dispo	sition (Name of natory or other place		Date Cember	20c. Location - City	
Ĕ	. Page ment tant: tant:		4 Donation 5 Other (Specify)		hsburg	Crematory	11	2010	Smithsburg	, Maryland
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important if fire 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Ocenses	M0143	22 K	Name and Address eeney & Bas 06 Fast Chu	s of Facility ford P.A. rch Street	Funeral H	Home Ick, Maryland	21701
			23a. Part 1. Enter the disease, or complications that	caused the death						Approximate
_ . ₽	Thysician/	5 4	shock, or heart failure. List only one cause on e Immediate Cause (Final disease or condition	ach line.	16					Interval Between Onset and Death
	Medical Examiner		resulting in death) Due to	(or as a consequ	ence of):		1 - 1 .			
		-	Sequentially list conditions, b.			imois C	ouni			mull
	ed nsit	шj	cause. Enter Underlying Cause (Disease or iinjury	(or as a donsequ	anda otjo					
i	xecut n and al-trar	Exa	that initiated events c.	(or as a consequ	ence of):					
9	death certificate be executed the attending physician and ed for use as the burial-transit	dical Examiner	d							
6876			IF FEMALE:							
9 ×	th cer tendii or use	ian/	23b. Was decedent pregnant 23c. If yes, or	utcome of pregnar Birth 2 Fetal	I death 3	Ectopic pregnancy	(23d. Date of o	
Вох	requires that the death certifics been signed by the attending p should be detached for use as t	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pre 9 ☐ Unknown 9 ☐ Unl	gnant at time of d known	eath 5	Other (specify)			Month	Day Year
О	that the ned by the detach		Part II. Other significant conditions contributing to	death but not resu	alting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use contribute	to the cause of death?
	irres t signi Id be	d by						1 🗆	Yes 2 🔼 No 3 🗌	Probably 4 Unknown
ord	law requires las been sign 2 should be	Completed						24a. Was		autopsy findings available
ec Ye	isician; The law is certificate has bilirector, page 2 s	mo							ormed? death	o completion of cause of ? /es 2 No
<u>a</u>	ian; I		25. Was case referred to medical examiner?		-	26. Pla	ce of Death (Che		2 2 10 1 1	es Z 🗆 NO
5	hysic his ce	욘	1 ☐ Yes 2 No Hospital: 1 ☐	Inpatient 2 🗆 I			4 Nursing F	lome 5 🗆 Resi	dence 6 Other (Sp	ecify)
ָה <u>י</u>	Ing P	Certificate:	1	e of injury nth, Day, Year)	28b. Time of injury	28c. Injury work?		28d. Describe	how injury occurred	
SIO	death ctor: y the	titic	2 Accident Investigation 3 Suicide 6 Could not be	e of Injury - At hor	me farm stre		∕es 2 □ No	28f Location /	Street and Number or F	Pural Poute Number
Division of Vital Records,	al or A s after Il Dire		4 Homicide determined build	ling, etc. (Specify)	mo, raim, oaro	ot, ractory, omoc		City or Tol		drai noute Number,
	or be coppinal or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner on the base only one) 3 Certifying Nurse Practioner	isis of examination	and/or investi	gation, in my opinior	, death occurred	at the time, date a	and place, and due to th	e cause(s) and manner stated.
	vithi To th		29b. Signature and title of certifier	-		29c. License	number		29d. Date signed (Mor	nth, Day, Year)
			1			D42	3091		4-7-1	e e e e e e e e e e e e e e e e e e e
_	10		30. Name and address of person who completed cau	se of death (Item	23a) (Type, Pr	tint) House	Ave,	Freder	4-7-1 nch, MI	721701
	Stat Registra	-	31. Date filed (Month, Day, Year) SEP 8 20 0	Registrar's Signatu	ire A.	parke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Physician/ Robert T. Rudy 2010 Рм 4:30 Medical 4b. City, Town, or Location of Death Potomac 4a. Facility Name (if not institution, give street and number) Examiner 4c_County of Death Montgomery Manor Care Potomac 5. Social Security Number Age (In yrs. 82 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 🕅 M 2 🗆 F Months Days Hours 579-32-3536 04^M30 / 1^y928 Washington, DC Director Usual Residence of Decedent show 10d. Inside City Limits ms 23a or 28a-f shor must be notified at 10a. State 10c. City, Town or Location Director 1^X Yes 2 □ No MD Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20854 Funeral 8148 Buckspark Lane East items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner Armed Forces?

1 X Yes 2 No 1952—
If Yes, Give ō þ 1 Never Married 2 X Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed 1954 Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Computers Systems Analyst event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marietta Thomas and Mental F Department of Health and Menta Important: If item 27 is marked any injury or other reconnections. ည Robert B. Rudy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8148 Buckspark Lane East Potomac, MD 20854 19a. Informant's Name/Relationship (Type, Print) 8148 Buckspark Lane East Nancy Darcey Rudy / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Falls Church, VA 9/11/2010 National Crematory 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licenses 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final) Physician/ Metastatic Cancer to Brain 3 Months disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Large Cell Lymphoma Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed' 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4X Nursing Home 5 - Residence 6 - Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Electifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

31. Date filed (Month, Day, State SEP 1 0 2010 Registrar

and title of certifie

owners

Thomas M. Masterson MD 1313 Dolley Madison Blvd. #302

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D50534

29d. Date signed (Month, Day, Year)

09/09/2010

McLean, VA 22101

			for State of I	Maryland		tment of He ficate of D		Mental Hy	/giene Reg. No	71111	29959		
	Physicia		1. Decedent's Name (First, Middle, Last) DORCAS RHODES					2. Date of De Month		81 2	3. Time of Death 2021 M		
ر الم	Medio Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death P. G.								eath		
	Funeral Director		5. Social Security Number 486-20-8635 6. Sex 1 M 2 F 94 Yrs. 7. Age (In yrs. last birthday)							9. E	Birthplace (State or Foreign Country) Cansas		
_	and show	ē	Usual Residence of Decedent 10a. State 10b. County		own or Locat						10d. Inside City Limits		
980	or 28a-f	Director	California Los Angeles 10e. Street and Number	Los	s Angel	Les 10f. Zip Code			10a. Ci	tizen of What	1 🗆 Yes 2 🗆 No		
	rs after death with the riral", or items 23a or Examiner must be	Funeral	2320 West View Street 90016 U. S. A.										
		þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced 12. Was Deceder Armed Forces 1 □ Yes 2 if Yes, Give Year or Dates	No No		s Decedent of His es, specify Cuban Yes 2x No		ecity tes of No Rican, etc.)		Black, Wh	nerican Indian, lite, etc. Black		
215-0	רטי 72 hou. an "natı Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 of		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business Industry				
d 212	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Co	12 17. Father's Name (First, Middle, Last)	1 5+)		Nurse	18. Mother's Nam	ne (First Middle		Medica	<u> </u>		
ylan			Samuel Brown		_	I	Besty U	nknown					
, Mar			19a. Informant's Name/Relationship (Type, Print) Carl M. Rhodes (Son)			Address (Street an East 122r							
nore,			20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place	e of Dispositi etery cremat HIII S	on (Name of ory or other place Memoria 1	al don't	Date 0.1		ocation - City			
Baltimore, Maryland 21215-0036	permit. Pa Departme Importan any injury once.		21. Signature of Funeral Service Licensee	FAIR	22. N	ame and Address	of Facility Hu	ntt Fun	era1	Home	, California		
			23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each I	ed the death. D		35 Old Water mode of dying,				ori, M	D 20601 Approximate Interval Between		
Physician/ Medical			Loon Bake Occur (Final		e e						Onset and Death		
Examiner)r	Immediate cause (Final disease or condition resulting in death) a. Septic shack Due to (or as a consequence of): Sequentially list conditions, b. Der tovated whether										
	icate be executed physician and s the burial-transit	Physician/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.										
0			resulting in death) Last Due to (or a	as a consequenc	ce of):								
68760	ertificate ding phy se as the		IF FEMALE: 23c. If yes, outcom	ne of pregnancy	/				Т	23d. Date of o	delivery		
). Box 68	requires that the death certific been signed by the attending should be detached for use as		in the past 12 months? 1 Live Birtl	1 Live Rith 2 Fetal death 3 Fetapic pregnancy							Day Year		
Division of Vital Records, P.O.	signed to	d by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to 1 Yes 2 XNo 3 Pro										
cord	aw requas been 2 shoul	Be Completed by						24a. Was	psy	24b. Were autopsy findings available prior to completion of cause of			
al Re	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		25. Was case referred to medical			26. Plac	ce of Death (Chec		ormed?	death'	es 2 No		
f Vita		은	examiner? 1 Ves 2 No Hospital: 1 Hospital: 27. Manner of Death 28a. Date of in	/Outpatient						ecify)			
o uo		Certificate:	Natural 5 Pending (Month, E		28b. Time of 28c. Injury at work? 28c. Injury at 2			28d. Describe how injury occurred					
Sivisi		Medical Certi	3 Usuicide 6 U Could not be determined 28e. Place of I building, 6					ation (Street and Number or Rural Route Number, or Town, State)					
_			29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	Hospi 24 hou Funer eted fill	e e	continue Nurse Practioner To the	29b. Signature and title of certifier				29c. License number			29d. Date signed (Month, Day, Year)		
	To the Hospi within 24 hou To the Funer completed fill		29b. Signature and title of certifier						29d. Da	te signed (Moi	nth, Day, Year)		
					a) (Type, Print	D00	69715		-	te signed (Mor	nth, Day, Year) 10 20735		
	To the Hospi within 24 hou To the Funer completed fill		29b. Signature and title of certifier 30. Name and address of person who completed cause of CHPETINE HANNAWY, W	death (Item 23a	1501 8	DOO	69715		-	re signed (Mon	10 20735 1001, MD		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last), Charles W. Sabina 2. Date of Death Physician/ 099-10-2098 0845 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 207 Bufflehead Drive Harford Havre de Grace Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 **X** M 2 □ F 019-34-6291 Months Hours 64 Director Massachusetts Usual Residence of Decedent should be filed within 72 hours and went were.

and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show

"" " " " " the Medical Examiner must be notified at. 10c. City, Town or Location Havre de Grace 10a. State 10b. County 10d. Inside City Limits Directo Harford Maryland 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 207 Bufflehead Drive United States of America 21078 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican. etc.) Black, White, etc by 1 Never Married 2 X Married Yes, Give 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Personnel Sgt. 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph John Sabina Stacia Ann Mileski permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any Injury or other traum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Bufflehead Vrive, Havre de Grace, Maryland 21078 Edward W. Sabina (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Garrison Forest 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 09-16-2010 Garrison, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. 21078 21. Signature 123 S. Washington St. Havre de Grace, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ance Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of, that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ g g Records, 2 No 3 Probably 4 Unknown Completed 1 X Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 Yes 2 No Yes Division of Vital Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tes 2 No 24 hours after death Funeral Director; A Investigation 6 Could not be Accident 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical (Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 TD Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

State Registrar 29b. Signature and fittle of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

00564

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 12, 8:45 A M September 2010 Michael Wayne Smith 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington 7827 Sharpsburg Pike Boonsboro | Months | Days | Hours | Min. | B. Date of Birth (Month, Day, Year) | July 20, 1957 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 1 M 2 □ F 219-68-0657 53 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7827 Sharpsburg Pike 21713 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Mason 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wayne Α. Smith Nancy Jean Leatherman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21713 7827 Sharpsburg Pike Boonsboro, Maryland Nancy J. Smith/Mother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09-15-2010 Sharpsburg, Maryland Mountain View Cem. 22. Name end Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD 21713 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Brophagea disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify)

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

Directo

Funeral

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Completed

Be ၉

ar than "natural", or items 23a or 28a-f sho the Medical Exa⊤iner nust be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

f Health and Mental Hygien Item 27 Is marked other th other traumatic event, I™

Department of Health Important: If Item 27 any injury or other to once.

Baltimore, Maryland 21215-0036

/Medical

Examine Physician/Medical ģ Completed Be

Certification: To

1 ☐ Yes 2 ☑ No 27. Manner of Death 1 Natural

2 Accident

4 Homicide

29b. Signature and title of certifier

3 Suicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

Medical

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

5 Pending investigation

6 ☐ Could not be

28a. Date of Injury (Month, Day, Year)

29c. License number

28c. Injury at Work?

1 □Yes 2 □ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Medical Campus

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. MCCormack 31. Date filed (Month, Day, Year)

1 4 2010

32. Registrar's Signature

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2:20 PM Eugene Paul Shank September 12, 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 20009 Rosebank Way 234 Washington A -Hagerstown Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day) Year Months Days Hours 1**X** M 2□ F 215-09-7309 89 Oct. 4, 1920 Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20009 Rosebank Way A - 234 21742 USA 12. Was Decedent Ever in U.S. Armed Forces? ↑★★ es 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2√No Specify. Specify: White 3XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer State Prison 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) McKinley Hobart Shank Lelia Jane Myers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis W. Shank - Son 729 Morningside Ave. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Donation 2. Removal from State Greenlawn Mem. Park | 09-16-2010 5 Other (Specify Williamsport, Maryland 21. Sign were of Fune al Serv 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21795 Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lilure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart fai Immediate Cause (Final disease or condition resulting in death) CITRENIC OBSTRUCTIVE WHL DISEASE 3 DAY Due to (or as a consequence of) YEAVU. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (r as a consequence of) Montes EBILITY Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💁 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

Director

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Completed

Be

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23a, Part

Item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Modical Experience in 1st be not that at

within 72 hours after death with

es 1 and 2 should be filed w of Health and Mental Hygier fitem 27 is marked other the

Pages 1 permit. Pages 1 Department of H Important: If Ite any injury or ot

Baltimore, Maryland 21215-0036

burial-

and attending physician for use as the buria signed by the a d be detached f certificate has be irector, page 2 sl director, After this funeral

The law requires that the death certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

ours after death.

neral Director: A
filled in by the fu

within 24 hours a To the Hospital completely 2+1 State

Examine Physician/Medical IF FEMALE Completed 25. Was case referred to medical Be Medical Certification: To 27. Manner of Death

examiner?

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

1 Yes 2 No

Storm 31. Date filed (Month, Day, Year) 14

29b. Signature and title of certifier

5 Pending investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28a. Date of Injury (Month, Day, Year)

MD

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

UMD

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an

1 ☐ Yes

Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify)

26. Place of Death (Check only one)

MACOUNTOWN

performe

2 No

28d. Describe how injury occurred

mo

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes

2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1190 Mr ADMA RADIA

32. Registrar's Signature

Registrar

Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: 24 hours after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 8, 2010 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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		Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Deat	h	U U	3. Time of Deal	19
Physicia		Flora Jane Sop	er				Month August	29	$20\overset{ ext{Year}}{10}$	2:35 P	М
/Medic Examin		4a. Facility Name (If not institution, give street and number			4b. City, Town, or	Location of Death		4c. County of Death			
		29693 Janet's Way		Easton			Talbot				
Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last i	birthday) . Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Mary	place (State or Fore htry)	ngn
Director		Usual Residence of Decedent	92			N	ſay 18,	1910			
ryland how		10a. State 10b. County	10c. City, To	wn or Loc	cation				1	0d. Inside City Lim 1 ☐ Yes 2 ☐	- 1
e Ma	Director	Maryland Talbot	Ea	ston	-1"			O Citi-	of Milhot Cour		
with th	ä	10e. Street and Number			10f. Zip Code 21601				of What Cou	es of Ame	ric
eath v	Funeral	29693 Janet's Way 11. Marital Status 12. Was Deceden	t Ever in U.S.	13. V	Vas Decedent of Hi f Yes, specify Cuba			14. F	Race - Ameri	can Indian,	
or iten		Armed Forces 1 Never Married 2 Married 1 Yes 2 If Yes, Give			fYes, specify Cuba I∐Yes 2 ∜ ⊡No	n, Mexican, Puerto Specify:	Hican, etc.)		Black, White,	etc.	
ural", c	d b	3 Vidowed 4 □ Divorced If Yes, Give Year or Dates:							Caucasian Kind of Business/Industry		
"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	lurina most of work	ing	16b. Kind o	f Business/Ir	austry	
withir than	d L	Elementary/Secondary (0-12) College (1-4or	5+)		Homemaker	,		Fam	ily Ho	me	
other ent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	•				
VIATIO uld be file Mental H irked oth	To B	Charles Stalin To				Flora Wa					
Wilding		19a. Informant's Name/Relationship (Type. Print)			ng Address (Street a						
e, E		Todd K. Vaughn Son			East Prat		, Daltill		on - City or T		
DEBILITION FOR WAITY HAIT OF A LATIONOR permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hyglene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinar must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	ceme	etery, cren	emetery	e) ¦			•		
Daltimo		4 ☐Donation 5 ☐Other (Specify) 21. Signature of Funeral Service Licensee	OIG W		2. Name and Addres	9/11 ss of Facility Moo	re Fune	ral Ho	ome, P	Maryland .A.	
B Dep De D		Hawloth P. Nove 12 South Second Street, Denton, Maryland 21629									
		23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between									
Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Sydia Can Cey Can Cey Can Cey									
/Medical Examiner		resulting in death) Due to (or as a consequence of):									
Examine	<u>-</u>	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):									
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exection and the sial-tra	Exa	that initiated events casulting in death) Last C. Due to (or as a consequence of):									
58 / bU, ficate be executed physician and s the burial-transit	edical Examiner	d									
certifica certifica nding pt	Med	IF FEMALE:			170						
BOX 58 leath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	f yes, outcome of pregnancy 1					23d.		Date of delivery Month Day Year	
that the death led by the atter detached for u	ıysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		5							
cords, P.O. w requires that the di been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death	but not resultin	g in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use	contribute to	the cause of death	?
requires t							1 🗆 \	es 2 A	lo 3∏ Pro	obably 4 🗌 Unkn	own
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The ate h	Completed		_				perfo 1 ☐ Yes	rmed?	death? 1 □ Yes	2 🗆 No	
VITAI iician: J certifica rector, p	æ	25. Was case referred to medical examiner?			ot all DOA Oth	26. Place of Dea					
JIVISION OT VITAI H(I or Attending Physician: The I after death. Director: After this certificate to be the funeral director, page	٦.	1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of I	ntient 2 ER	Outpatie	f 28c. Injur	y at	ome 5 Residence 1			cify)	
On Iding th. After	tion	1 Natural 5 Pending (Month, Day, Year) Injury Work? 2 Accident investigation M 1 Yes 2 No									
DIVISION I or Attending after death. I Director: After d in by the func	ifica	3 Suicide 6 Could not be 28e. Place of	njury - At home	, farm, str	reet, factory, office		28f. Location (S	Street and N vn. State)	umber or Ru	ral Route Number,	
Lalor rs after all Dir	Certification:	4 ☐ Homicide determined building, etc. (Specify) City or Town, State)									
DIV To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier 1 Certifying Physician: To the be (Check only one) 1 Medical Examiner: On the basis and manner	of examination	edge, deat n and/or ir	th occurred at the ti nvestigation, in my o	me, date and place opinion, death occu	e, and due to the rred at the time,	cause(s) an date and pla	id manner as ace, and due	stated. to the cause(s)	
o the vithin of the complex	Mec	29b. Signature and title of certifier			29c. Licens				igned (Month		
F > F 0		chya M	0		00	75/13	2	J's	-3/-1	10	
		30. Name and address of person who completed cause of	f death (Item 23	3a) (Type,	Print)						
		Jorge Abrego, M.D., 59	8 Cynw strar's Signature	ood D	rive, Sui	ite 104, E	aston, l	Maryla	ind 2	1601	
StaRegistr		31. Date filed (Month, Day, Year) 32. Regi	strar's Signature	bo	de						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 09106 i 2010 Steinacker 12:51 Medical <u>Anna</u> 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico 31267 East Line Rd. Delmar 5. Social Security Number if Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 D M 2 X F Hours 0712611946 64 Director 218-48-8137 Austri Usual Residence of Decedent 28a-f show 10a. State er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🏝 No Maryland Wicomico Delmar 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 31267 East Line Rd. 21875 USA death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 X Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 nours after 1 Yes 2 No Specify: Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, <u>the Me</u> College (1-4 or 5+) Elementary/Seconday (0-12) Cook Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Karl P. Mohr Anna Dormuth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31267 East Line Rd., Delmar, MD 21875 Leonard Steinacker husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Springhill Memory Gardens 09 11 2010 Hebron, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Living 22. Name and Address of Facility H811 Sway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Onderlying Cause (Disease or linjury Examine Due to (or as a consequence of): -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached for 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 A No certificate has 1 ☐ Yes 2 No 25. Was case referred to medical npleted filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 K No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 \(\subseteq \text{Yes} \quad 2 \(\subseteq \text{No.} \) X Natural injury 5 Pending 24 hours after death. Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

within 2

State Registrar

Medical

29a. Certifier

(Check

Robert

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

560 Alversid

mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Biol Salisbury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Physician/ ^{Day} 2010 Sept. Ilias N. 7:46 p M Triantis 7, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda **Funeral** Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 579-72-9451 1 XM 2 F Months Days Hours Min. (Month, Day, Year) Director 92 1917 Sept Greece Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified Maryland Montgomery Bethesda 1 Yes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9012 Ewing Drive 20817 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 14. Race - American Indian, Black, White, etc. White Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ge 1 and 2 should be filed within 72 hours aft nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or other traumatic event, the Medical Exal If Yes, Give 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waiter Hospitality Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nicholas Triantis Sophia Papoutcakis 19a. Informant's Name/Relationship (Type, Print) Maria Y. Triantis/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9829 Belhaven Road, Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State cemetery, crematory or other place) Metropolitan Crematory 1 Burial 2 Cremation 3 Removal from State 9/13/10 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility M00810 Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring. MD 20901 23a. Part 1. Enter the disease, or op plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Pneumonia disease or condition 2 days Medical resulting in death) Due to (or as a consequence of): Examiner Stroke Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) 2 tran Due to (or as a consequence of): ã Physician/Medical certificate be Box 68760 D as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No the 1 g Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Respiratory Failure, Acute Renal Failure, Dysphagia, 1 ☐ Yes ŽŽ No 3 ☐ Probably 4 ☐ Unknown Completed \$250 Dementia, Failure to Thrive, Anemia 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 1 Yes 2 N 1 Yes 2 No 4 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🛣 No 1 A Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Yes 2 No 1X☐ Natural 2 ☐ Accident 5 Pending injury investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State,

P.O. Records, ne Hospital or Attending Physician: The n24 hours after death.

The Funeral Director: After this certificate oleted filled in by the funeral director, ps Division of Vital within 24 hours a

To the Funeral C

completed filled Medical てせ 5

31. Date filed (Month, Day, Year) SEP 1 0 2010 State Registrar

29a. Certifier (Check

29b. Signature and title

of certifie

Rajan Shyamsundar, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9801 Georgia Avenue, #117, Silver Spring, MD 20902 egistrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D53367

29d. Date signed (Month, Day, Year)

Sept. 8, 2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year 2010 Herman V. Trader, Jr. Sept 12:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Worcester Harrison Senior Living Snow Hill 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 1**X** M 2 □ F Months Days Hours 2/20/1930 Maryland Yrs Director 80 217-28-2566 Usual Residence of Deceden 28a-f show ral", or items 23a or 28a-f shorexaminer must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🏻 No MD Stockton Worcester 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 37004 State Line Road 21864 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White "natural" 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education iit. Page 1 and 2 should be Tireu artment of Health and Mental Hygiene. if item 27 is marked other than "n: 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Agriculture Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Elaine Katherine Hart Herman V. Trader, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37004 State Line Road, Stockton, MD 21864 Elizabeth Trader (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 XBurial 2 Cremation 3 Removal from State 9/10/2010 Powellville, MD 4 ☐ Donation 5 ☐ Other (Specify) Powellville Cemetery 21. Signature of Funeral Service License Holloway Furieral Home, Professional Association 107 Vine St., Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line MISEASE Immediate Cause (Final Onset and Death ATHEROSCLEADTIC CARNIOVASULAR Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ó in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year the 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death. e Funeral Director: Afte bleted filled in by the fur 2 Accident 3 Suicide 4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical

State Registrar

completed To the I within 2 To the F

29a. Certifier

SHARAD

29b. Signature and title of certifier

R

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMAL, MD 1604 MARKET ST. egistrar's Signature

Box 68760

P.O.

Records,

of Vital

Division

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

00062172

29d. Date signed (Month, Day, Year)

0102/8/6

POLOMOKE CITY MD

29c. License number

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Josephine /ථ Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death County of Death d Manor Nursinston klan Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Hours Min. 90^{Yrs.} Director Maryland 5-58-6360 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No Accident MD Garrett 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21520 U.S.A. 1550 Harman RD. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2**X** No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar Peck Charles Jane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21550 2336 Oakland-Sang Run RD, Oakland, Donald Upole/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Deep Creek 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Important: It any injury or Baptist Cemetery 9/10/2010 McHenry, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Newman Funeral Homes P.A. S Second St., Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death CONGESTIVE Physician/ HEART disease or condition resulting in death) Fairuns Medical Due to (or as a consequence of): Examiner AKDIO Sequentially list conditions, Examiner cause (Disease or linjury Dus to for as a sonscauenes on the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 morths? 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 7 is certificate has been signed by the director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe we After this certificate NON 1 ☐ Yes 2 ☐ No 25. Was case re erred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of N	/laryland / Dep	oartment of e <i>rtificate o</i>		_	giene Reg. No. 20	10 29971
			Decedent's Name (First, Middle, L.)	ast)			, Dod.,	2. Date of De	ath	3. Time of Death
	Physic /Medi		Harry		Vit	ez		Sept.	9, 2010	10:35A ^M
	Exami	ner	4a. Facility Name (If not institution, g			4b. City, Town	, or Location of D	eath	4c. County o	
	F		Garrett County 5. Social Security Number 6.		l Hosp. Age (In yrs. last birthda	Oaklai	nd ar If Under 24	Hrs. 8. Date of Bir	Garr	ett
	Funeral Director		215-20-6735	1 🖳 M 2 🗆 F	88 ^{Yrs.}			Min. (Month, Da		9. Birthplace (State or Foreign Country)
	pu ^		Usual Residence of Decedent					4/16/	1922	Maryland
	laryla shov	5	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits 1 XYes 2 No
	the N	Director	MD Garre	tt	Acc	ident 10f. Zip Code			10g. Citizen of Wi	
	3a or	Ö	102 Accident-B	ittingor	· DD		520			•
	death	Funeral	11. Marital Status	12. Was Deceder Armed Forces				? (Specify Yes or No uerto Rican, etc.)	U.S.,	- American Indian,
36	s after death with the Marylan ",or items 23a or 28a-f show or irea must be a citied at	by Fu	1 ☐ Never Married 2 ☐ Married		MNo	1 ☐Yes 2X N		uerto Hican, etc.)	Specify:	, White, etc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the the yield Eventing must be notified at	q pa	3 ☑ Widowed 4 □ Divorced	Year or Dates						White
215	nin 72 In "na Medic	plet	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	rade completed)	(Giv	edent's Usual Occ re kind of work don DO NOT use reti	e during most of red)	working	Garret	t County
21	yd with	Completed	10	College (1-4o	, I	nanic			Roads	
Maryland	<u>e e e e</u>	Be	17. Father's Name (First, Middle, Las	st)			1	Name (First, Middle,	Maiden Surname)
Ŋ	d Mer marke	မ	John			Vitez	Eliza			Czeranko
Ma	es 1 and 2 should b of Health and Ment item 27 is marked r other traumatic e		19a. Informant's Name/Relationship Caroll E. Vite					r Rural Route Numbe		
altimore,	of Hea		20a. Method of Disposition		20b. Place of Disp	YOUNGS1 position (Name of ematory or other p	cown RD	Date Lemor		ace PA 15456 City or Town, State
m 0 E	Pages nent of int: If i		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	=	ematory or other pi emetery	i	12/2010	n aaidan	it, Maryland
alti	permit. Pages Department o Important: If i any Injury or once.		21. Signature of Funeral Service Lice		21011 (22. Name and Add	ress of Facility N	ewman Fu	neral I	Homes P.A.
8	20 E 29		Feil Matte	1/	11	79 Mil]	Ler St.	,Grantsv	ille, N	MD 21536
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	mpi sthat cause y one cause on each	ed the death. Do not e line.	nter the mode of d	ying, such as car	diac or respiratory as	rrest,	Approximate Interval Between Onset and Death
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- u	Tric brai	in inj	urg			days
7	Examiner		4	M	s a consequence of):	Ec Dinat	2.c. +	oilune		le e
	D +	je	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	s a consequence of):	7/11/11/10		arture		ove, s
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events	c. ALTE	Stell (E)	tel ot	COLS	cious re	289	dass
8760,	icate be executed physician and the burial-transit	<u>e</u>	resulting in death) Last	Due to (or a	s a consequence of):					/
	ficate phys s the	edical		d						
Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom					23d Date	of delivery
Ö.	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 🔲 Pregnant		☐ Ectopic pregnar ☐ Other (specify)	ncy		Mont	
P.0	at the d by th	hys	9 🗆 Unknown	9 ∐ Unknown						
Ś,	Physician: The law requires that the death certificate this certificate has been signed by the attending rail director, page 2 should be detached for use as		Part II. Other significant conditions	* /	but not resulting in the	underlying cause g	iven in Part I.			oute to the cause of death?
Ö	w requir been s should	eted	000/009 0	(VIERY	0115444			1 🗆 Y	′es 2 🖸 No 3	B Probably 4 Unknown
Division of Vital Records,	ne law e has ge 2 s	Completed by						– 24a. Was a autop	sy pri	ere autopsy findings available for to completion of cause of eath?
tal	slcian: The certificate h rector, page		25. Was case referred to medical					1 □ Yes	2 ☐1Ño 1 [Yes 2 No
Ξ	is cer direct	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ient 2 ☐ ER/Outpatie	ent 3 DOA O		Death <i>(Check only of</i> g Home 5 ☐ Resid		(Saacihi)
0 U	ng Te	Ë	27. Mann of Death 1 Natural 5 ☐ Pending	28a. Date of In	ury 28b. Time				now injury occurred	
sio	vttendil death. ctor: A y the fu	catic	2 Accident investigation	on		M 1[□Yes 2□No			
ΣĬ	or At after d Direct in by	Certification: To	4 Homicide determined	28e. Place of In building, e	jury - At home, farm, si tc. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tow		r or Rural Route Number,
_	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the funer		29a. Certifier 1 Certifying P	hysician: To the hes	t of my knowledge, dea	th occurred at the	time date and al	lose and due to the	acusa(a) and man	annu an atatad
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Exa	miner: On the basis and manner s	ot examination and/or i	nvestigation, in my	opinion, death o	ccurred at the time,	date and place, an	id due to the cause(s)
	Vithi Vithi Com	ž	29b. Signature and title of certifier	/	-	29c. Licer	nse number		29d. Date signed	(Month, Day, Year)
			1/4/1	10	11)	0	10618	501	9/9	1/10
		, [30. Name and address of person who		death (Item 23a) (Type	, Print)	X	, ouklard	/	
	Sta	8	31. Date filed (Month, Day Year)	((74/2 (c)	rar's Signature	r, 41, 25	Sufit 1	, oaklard	mp 21	550
	Registra		SEP 1	0 2010	some B.	parlie				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Da Physician/ ^{Year} 2010 0156 M Merry Elizabeth Vlahos 07 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 3601 Webster Street Brentwood 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Couptry) Washington. Days 1 🗆 M 2 🗓 F Months 09/25/1920 Director 579-18-5527 89 DC Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Brentwood Maruland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20722 U.S.A 3601 Webster Street death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married "natural", or Completed by 1 ☐ Yes 2 💢 No If Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify 3 ♥ Widowed 4 □ Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Dancer Entertainment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Ireland Maru Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Michael G. Vlahos - Son 5310 Pommel Drive. Mount Airy. Maryland 21771 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Ft. Lincoln Cemetery 09/11/2010 Brentwood, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 401024 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. ala 11800 New Hampshire Ave., Silver Spring, MD 20904 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sist only one cause on each line. 23a. Part 1. Enter the slise shock, or heart failure Onset and Death Immediate Cause (Final Atherosclerotic Cardiovascular Heart Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for se a consequence of: e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

E Funeral Director: After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? performed 1 Yes 2 No 1 ☐ Yes 2 ☐ 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending work? 1 ☐ Yes 1. Natural 2 🗌 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npleted 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifier 0

State Registrar 31. Date filed (Month

12

egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Evelyn G. Williams 2010 6:30 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2658 Melba Road Ellicott City Howard . Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛚 F Days Min. Months Hours (Month, Day, Year) 6/4/1923 Country) 294-14-8554 Director 87 NC Usual Residence of Decedent or 28a-f show 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits by Funeral Director 1 🗆 Yes 2 🔀 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2658 Melba Road 21042 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 24 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give White 3 ☑ Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o မှ Milas W. Glover Theresa I. Mahaley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau James Williams - Son 2658 Melba Rd. Ellicott City Baltimore, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Çremation Gate of Heaven Cem. 9/11/10 5 1 Other (Specify) Entombet. Silver Spring, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 21. Signature of Funera 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line brocomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ CARDIORESPIRATORY Medical Due to (or as a consequence of) Examiner DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death ed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OSTEOPOROSIS 1 Yes 2 No 3 Probably 4 X Unknown HYPERTENSION Were autopsy findings available prior to completion of cause of 24a. Was an page 2 performed 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate; 28d. Describe how injury occurred Natural 5 \square Pending 1 Tyes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier PHYSICIAN leck 0062704 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ridge Road 3290 M. Desai MA artik

DHMH 17 Rev 7/2009

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Day Sept 7, Physician/ Bedford Forrest Witherspoon, Jr. 5:50 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 11530 Cedarville Road Brandywine 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. (Month, Day, Ye. Country)
Jackson 11⁄2 M 2 □ F 415 26 4348 86 Director Apri Usual Residence of Decedent 28a-f show 10b County 10c. City, Town or Location 10d. Inside City Limits 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ☐ Yes 2 XXNo Maryland Prince George's Brandywine 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code Funeral 11530 Cedarville Road United States 20613 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 2 No Specify: White 1 Yes 2 V No Specify: WII Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Manager Sears Automotive injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file.
Department of Health and Mental h.
Important: If item 27 is marked any injury or cat. and Mental Fisherships is marked of 2 Bedford Forrest Witherspoon, Sr. Sarah Irene Crutchfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myrtle Witherspoon (Wife) 11530 Cedarville Road, Brandywine, MD 20613 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Date 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other Specify) cemetery, crematory or other place) Maryland Veterans Cemetery Sept 14, 2010 Cheltenham, MD Signature of Funeral Service 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 24 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes XX No certificate 2 \square No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 X No 4 Nursing Home 5 X Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: To the Hospital or Attending 5 Pending 1 Yes 2 🗆 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tip 0070102

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 0 2010

31. Date filed (Month, Day, Year)

Ivan Zame, M.D. 9200 Basil Court #200, Largo, MD 20774

32. Registrar's Signate

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 2010 Sept. 1:00A M CORA WRIGHT WILLEN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Federalsburg 5242 Preston Road 8. Date of Birth (Month, Day, Year) Aug. 10, 1921 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√□ F 89 **Director** 212**-**14-4293 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f show event, the Medical Expression reast by motified at Director Federalsburg 1 ☐ Yes 2 🕅 No MD Caroline 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? United States 21632 5242 Preston Road death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. em 27 is marked other than "natural", or ite 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: or i 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ∐Yes 2√∑No Specify: White Specify: 含 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) III grad College (1-4or 5+) Food Service Mobile Catering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Madge Hubbard Wright Oscar Wright ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau
once. 5242 Preston Rd., Federalsburg, MD 21632 Kathie Ostrowski/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/16/10 Federalsburg, MD Hill Crest Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RELocecc Framptom Funeral Home, Federalsburg, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician for use as the buriar P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown þ signed I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: The certificate Division of Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide cal 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the within 7 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 920 MD Marke aM 32. Registrar's Signature 4 3 2010 State Registrar

12/5

5 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 304 M F1oyd Joseph White Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10 astor If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday, **Funeral** 1 □_XM 2 □ F May 14, Months Days Hours Min Maryland Director 218-10-0417 90 Usual Residence of Decedent Important; If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Caroline 1 x Yes 2 No Maryland Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 207 Maple Avenue 21639 United States of America 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc." 1 Never Married 2 Married 1 ___Yes If Yes, Give 2 🗆 No 1941 1945 1 Yes 2x No Specify: Specify: Caucasian 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important; If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Automobile Repair Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Floyd Joseph White Hilda Wilhelmina Kershaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Wright Daughter 14 South Eighth Street, Denton, Maryland 21629 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) TX Burial 2 Cremation 3 Removal from State Greensboro Cemetery ! 4 Donation 5 Other (Specify) 9/7/2010 Greensboro, Maryland 22. Name and Address of Facility Moore Funeral Home, P.A. 21. Signature of Funeral Service Licens South Second Street, Denton, Maryland 21629 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Immediate Cause (Final Onset and Death Physician pheumona disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi DAGESTIVE attending physician I for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ₺ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed certificate 1 Yes 2 No 2 🖪 N Yes funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 🗌 Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🖯 within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar e and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 1030aM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Count 0 town If onder 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Hours Min. Feb. 19,1921 Ohio 220-05-6239 Director 89 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show important of the traumatic event, the Medical Examiner must be notified at angle. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 ☐ Yes 2 🛣 No 10f. Zip Code 10g. Citizen of What Country? Funeral 18919 Dover Dr. 21742 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 X Yes 2 If Yes, Give 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ρ 1 X Yes 2 No If Yes, Give 194 Year or Dates. 1 Never Married 2 XMarried Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Doctor Private Practice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ J. Atlee Young Edith Potter Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18919 Dover Dr. Hagerstown, MD 21742 Martha L. Young-wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rest Haven Cemetery 9-14-2010 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home Eastern BLvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head ailure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner It any leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 24 hours after death.

• Funeral Director: After this certificate letted filled in by the funeral director, pag 2 🗀 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ည 1 🗌 Yes 2 **N**O 1 Nonpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 \square Pending 1 Yes 2 🗌 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) 4DD068976 0110 MD + 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11 M (1) 31. Date filed (Month, Day, State Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 29978
State of Maryland / Department of Health and Mental Hygiene

		1- For State Certific Registrar	ficate of	Death		Re	∍g. No.	
Physici		Decedent's Name (First, Middle,Last)				2. Date of Deat	th Day Yea	3. Time of Death
Medical Exam	iner	dason Daniel Denjamin Anderson				Septembe	r 20, 2010	1857 hrs
		Facility Name (if not institution, give street and number) Good Samaritan Hospital	4	b. City, Town, o Baltimore	r Location of Deal	h	4c. County of	of Death
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Ye			,	9. Birthplace (State or Foreign
Director		032-66-1921 1XXM 2 F 32	Yrs.	IVIOTIUIS DA	ys Hours Will	July	7,1978	Country) MASS.
any		Usual Residence of Decedent 10a, State 10b, County 10c, City, To	own or Location	on				10d. Inside City Limits
*		MD Ralti						1 Y Yes 2 No
Maryland 28a-f show 1 at once.	cto	10e. Street and Number		10f. Zip Code		10	Og. Citizen of Wh	
ith the Maryland 23a or 28a-f sho notified at once.	Director	3922 Corse Avenue		2120	16		USA	•
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-7 sho injury or other traumatic event, the Medical Examiner must be notified at once		JJEE GOIDE MYCHAC	13. Was	Decedent of Hi	ispanic Origin? (S	Specify Yes or No-	14. Race	- American Indian, Black,
death or iten	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Ye	s, specify Cuba	n, Mexican, Puert	o Rican, etc.)	White	e, etc.
after ral", c	by F	3 Widowed 4 Divorced if tes, Give Year or Dates:		Yes 2 X No			Specify:	White
hours natus					ation (Give kind of e. DO NOT use re		16b. Kind of Bu	siness/Industry
36 hin 72 e. than '	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) 1 2 5 C	uctomo	r Accou	ınt Execu	14177	Comoo	-+
5-0036 lled within 7 Hygiene. tother than	Con	17. Father's Name (First, Middle, Last)	uscome	I ACCUL		e (First, Middle, N	Comca Maiden Surname)	
21215 ould be fill Mental H marked ic event, il	Be				Joycelyr	Florris	s Ricker	
21 hould nd Me is ma	ဥ	1			et and Number or	Rural Route Num	ber, City or Town	n, State, Zip Code)
MD and 2 sho alth and sm 27 is		Katrina Anderson 20a Method of Disposition 20b. Plac		Corse A	venue Ba			
Ore, es la of He If ite			latory or othe		emetery,	Date	20c. Location -	City or Town, State
Baltimore, Dermit. Pages I ar Department of Hes Important: If ite				remetor		.23,2010	G1en	Burnie MD
Bal Bermil Depar Impor		21. Signature of Funeral Service Licen ee						me of Lansdown
Physician		23a. Part I. Enter the disease, or complications that caused the death Do						e MD 21227 Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Cardiac Hypertrophy		, ,		, ,		Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Cardiac hypertrophy Due to (or as a consequence of):						
	L	Sequentially list conditions, b. Bicuspid Aortic Valvular D	isease					
	ine	if any, leading to immediate Due to (or as a consequence of):						
ı i	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		. <u>-</u>				-
760, cate be executed physician and the burial - transi		d						
760, cate be ex physician the burial	Medical	UNPENDED AMENDED					_	
		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant 1 Live birth		ideath 3	Ectopic pregna	ancv	23d. Date of o	delivery Day Year
OX 68 sath certifi attending or use as	sician	past 12 months? 4 Pregnant at time of death		er (Specify)				,
Box he death c the atten hed for us	Phys	1 Yes 2 No 9 Unknown 9 Unknown				Loo - Luc		
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certif 24 hours after death. Functal Director: After this certificate has been signed by the attending tely filled in by the funeral director, page 2 should be detached for use as	by F	Part II. Other significant conditions contributing to death but not result	ting in the und	derlying cause (given in Part I.			pute to the cause of death? Probably 4 Unknown
ds, lequires	ted	L				24a. Was a		Vere autopsy findings available
COFC law re has be	Completed					autops perform	ву рг	rior to completion of cause of eath?
of Vital Records, ng Physician: The law require ufter this certificate has been si neral director, page 2 should b	ပ္ပ					1 ✓ Yes 2		Yes 2 No
irector	Be	25. Was case referred to medical examiner? 1	Outpatient		of Death (Check Other Nursir		Residence 6	Other:
of V g Physical differ thi	은	27. Manner of Death 28a. Date of Injury 28t	b. Time of Inju		ry at Work?		ow injury occurre	
on on ath.	티	1 V Natural 5 Pending (Month, Day, Year)		1	Yes 2 No			
Division tal or Attendi rs after death. al Director: A	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home,	, farm, street,	factory, office b	ouilding, etc.			r or Rural Route Number, City
Oi ours af	Certification:	4 Homicide determined (Specify)				or Town, St	ate)	
0 - 0		29a. Certifier 1						
To the within To the compl	Medical	and manner stated. 29b. Signature and title of certifier		29c. Licens		,		d (Month, Day, Year)
		(V Lacous)		O.C.			September	
	-	30. We'me and address of person who completed cause of death (Item 23a	a)					
(Laron Locke MD. Assistant Medical Examiner 1		Street, Baltir	nore, MD 212	.01		
	ate	31. Date filed (Month, Day Year) SEP 2 4 2010 32. Registrar's Signature	1. 1.	and				
Regist	цец	API MIPAIN VOICE	17					

State Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year)

AVen, Cathorine

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of N	/laryland		artment of H tificate of D			giene Reg. No. 0 1 (29980
7	Physicia	n/	1. Decedent's Name (First, Middi	le, Last)					2. Date of Dea		3. Time of Death
	Medic	al	Patricia Ann						Sept	ember 18,	2010 4:30 AM
	Examin	er	4a. Facility Name (If not institution Villa Rosa N				4b. City, Town, or	Location of Death Bowie		4c. County of D	eath e Georges
-	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	h 9,	Birthplace (State or Foreign
	Director		171-30-0917	1 □ M 2 🕱 F	72	Yrs.	Months Days	Hours Min.	(Month, Day Dec	28, 1937	Country) Pennsylvania
	nd thow	٥٢	Usual Residence of Decedent 10a. State 10b. County	/	10c. City,	Town or Loc	ation				10d. Inside City Limits
	Aaryla 8a-f s tified	Director	MD Pri	ince Georges	В	owie					1 🗆 Yes 2 🔀 No
	a or 2 be no	iO le	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?
	th with ms 23 must	Funeral	3800 Lottsfor				2071			United	States
36	ould be filed within 72 hours after death with the Maryland dol Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at.	þ	11. Marital Status1 ☐ Never Married 2 ☐ Ma3 ☐ Widowed 4 ☑ Divorce	If Yes, Give	?	If	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 ☑ No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	
21215-0036	hours natura lical E	Completed	15. Decede	ent's Education			ent's Usual Occupa		1	16b. Kind of Busine	White ss Industry
215	iin 72 ie. han "r e Med	dmo	(Specify only high Elementary/Seconday (0-12)	est grade completed) College (1-4 or	· 5+)		ind of work done d NOT use retired)	uring most of work	king	TOD THING OF BUSINES	oo maasay
	d with tygien ther tl nt, the	Be C	12			Hom	emaker			Own Hor	ne
anc	be filed ental Hy ked oth c event	To B	17. Father's Name (First, Middle, Manus John O						ne <i>(First, Middle, I</i> Margaret	Maiden Surname)	
Maryland	should be file and Mental I is marked o raumatic eve		19a. Informant's Name/Relations			19b. Mailin	g Address (Street a	-		City or Town, State,	Zip Code)
Σ̈́	id 2 sh ealth a n 27 is ertrai		Kenneth Batt	ye /Son			-			e, MD 2106	' '
Baltimore,	je 1 ar t of He If iten or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation	3 Removal from Sta			sition (Name of natory or other place	e)	Date Sep 22	20c. Location - City	· ·
Ħ,	it. Pag rtmen rtant: njury		4 Donation 5 Other ((Specify)	Ch		ake Crema		2010	Beltsvi	lle, Maryland
Ba	permit Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		21. Signature of Funeral Service	ne Rette	40140	£3 ^{22.}		n and Fun			vland 21286
			23a. Part 1. Enter the disease, o shock, or heart failure. List	r complications that cause only one cause on each li	ed the death.	Do not ente					Approximate Interval Between
~P	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	- a Hyper	lens	ive	Cond	io vas	Cula	1 Dixus	On and and Doobh
and the	Examiner		resulting in death)	Due to (or as	a conseque	ence of):	1001	a T	, 6	n Dixus	
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or a:	s a conseque		W)LIGHT		Hu		Trans
-	uted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	с							
	cate be executed physician and the burial-transit	al E	resulting in death) Last	Due to (or as	s a conseque	ence of):					
760	cate b physic the b	edical		d							
. Box 68	Ine law requires that the death certificate be executed rate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2. No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Fetal at time of de	death 3 🖳	Ectopic pregnancy Other (specify)	1		23d. Date of Month	delivery Day Year
P.O	requires that the de been signed by the should be detached	질	Part II. Other significant conditi	4-	but not resul	ting in the ur	nderlying cause give	en in Part I.	23e, Did to	bacco use contribute	to the cause of death?
ds,	quires en sigi vuld be	ted t	Diahete	28 M-	2 Hi	tus			1 □ Y	′es 2 X No 3 □	Probably 4 🗆 Unknown
Records,	sician: The law rec certificate has be lirector, page 2 sho	Completed by							24a. Was a autopoperfor 1 Yes	sy prior t med? death	autopsy findings available to completion of cause of ? Yes 2 \sum No
[a]	cran: ertifica ector, p	Be	25. Was case referred to medical examiner?	Haavitali				ce of Death (Chec			
<u>`</u>	Pnysic this c	၉	1 ☐ Yes 2 No 27, Manner of Death	Hospital: 1 ☐ Inpa 28a. Date of inj	tient 2 E	R/Outpatient		4 La Nursing He		ence 6 Other (Sp	pecify)
0 "	th. After funer	cate	1 Natural 5 Pendi		ay, Year)	injury	28c. Injury work? M 1 🔲	at ∕es 2 □ No	28d. Describe ho	ow injury occurred	
Division of Vital	er dea ector: by the	Certificate:	3 Suicide 6 Could 4 Homicide detern	not be 28e. Place of In	jury - At hom tc. (Specify)	ne, farm, stre	et, factory, office			reet and Number or I	Rural Route Number,
בֿ בֿ	piral ol ours aft eral Dii filled in		00 0 115 1 150	7					City or Town		
	to the nospital or Attending Prhysician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, i	Medical	only one) 3 Certifying	g Nurse Practioner: To the	examination a	and/or investi	gation, in my opinior	i, death occurred a	it the time, date an	nd place, and due to th	ne cause(s) and manner stated.
	vit cor		29b. Signature and title of certifie	hond	79	MI)	29c. License	2016	8	29d. Date signed (Mo	nth, Day, Year)
			30. Name and address of person	as 1430	000	aller	ut Fo	clni	Bruin	e, MD	26715
	Stat Registra	_	31. Date filed (Month, Day, Year) SEP 2		rar's Signatu	B. A	iak			,	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#19a, perFH, G909, 10/1/2010, WS
State of Maryland/Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 20, 2010 9:35 Pм Janet Marlyn Bennett 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Genesis Cromwell Center Parkville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 07-05-1930) 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2**X** F Yrs. 80 212-28-6065 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No N/A Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2837 Chesterfield Avenue 21213 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify. Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Dudonis Eugene Leight 19a. Informant's Name/Relationship (Type. Print)

Mr. Michael E. Bennett - Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2837 Chesterfield Avenue Baltimore, Maryland 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State Hilltop Service Corp. 09-22-2010 Towson, Maryland 4 □ Donation 5 ☐ Other (Specify) 21. Signaty 7/19 Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that Q used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause in each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 44 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation ↑ □ Natural 2 □ Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

permit. Pages 1 and 2 should be filed within 72 hours after death w Speartment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a-part Injury or other traumatic event, the Medical Examiner must bonce. Baltimore, Maryland 21215-0036 Physician /Medical **Examiner** burial-tran P.O. Box 68760. attending physician for use as the buris pe the as nse : signed by the a Division or Vital Records, cate has been si page 2 should b Physician: funeral director, this e Hospital or Attending PI 24 hours after death. e Funeral Director: After the letely filled by the funeral To the Hospital or within 24 hours at To the Funeral D

Physician

/Medical

Examiner

Funeral

Director

3a or 28a-f show t be notified at

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Physician/Medical

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Certification:

Medical

State Registrar 29a. Certifier
(Check only one)

29a. Certifier
(Check only one)

29b. Signature and fille of certifier

29c. License number

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and oddress of person who completed cause of death (Item 28a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

SEP 2 4 2010

29d. Date of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar		State of Ma	-		cate of E		and wei		Reg. No.	2010) (29982
	Physicia Medic		1. Decedent's Name (File		BROWN						Date of Dea Month	Day	71, 701.	r	3. Time of Death
	Examir		4a. Facility Name (if not	institution, give s	treet and number)			City, Town, or		f Death	er rec	4c.	County of D	eath	
	Funeral Director		5. Social Security Numb 212-42-638	er 6. Sex 3 1 2		(In yrs. last birth	day) If	Under 1 Year nths Days		24 Hrs. 8	Date of Birt (Month, Day in 22	h	13		e (State or Foreign
	show dat	tor	Usual Residence of Dec 10a. State 10a	o. County		10c. City, Town	or Locatio	n						10d	Inside City Limits
	e Mary r 28a-1 notifie	Director	Maryland 10e. Street and Number		Arundel				en Bu	rnie					1 ☐ Yes 2 ☑ No
	with th	Funeral I	220 Glen					of, Zip Code	2106	50		10g. Cit	izen of What	Country ISA	?
920	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	b	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐	2 🖾 Married	12. Was Decedent E Armed Forces? 1 12 Yes 2 1 If Yes, Give Year or Dates.			Decedent of Hi , specify Cuba Yes 2 🗵 No		in? (Specify Puerto Rica	Yes or No- an, etc.)		14. Race - Ai Black, W Specify:	hite, etc.	
21215-0036	ithin 72 hou ene. : than "nat u he Medica	Completed		Decedent's Edu only highest grad by (0-12)			Give kind life. DO NO	Usual Occupa of work done d Tuse retired) ispctcl	luring most o	of working			nd of Busine		
b	be filed w ental Hygi rked other ic event, t	To Be (17. Father's Name (First, John R		n	<u>.</u>		rspecci		r's Name <i>(Fi</i> i	rst, Middle, Linsc	Maiden S		OIL	acion
lary	12 should be lith and Ment 27 is marked r traumatic e		19a. Informant's Name/	Relationship (Typ	e, Print)	19b.	Mailing Ac	dress (Street a	and Number	r or Rural Ro	ute Number	r, City or	Town, State,	Zip Coa	(e)
e,	and 2 Health tem 27 other tr		Joyce D. B:		(spouse	20b. Place of		len Roa	ad, Gl	len Bu Date			21060 ecation - City	or Town	State
I O E	Page 1 nent of ant: If it		1 ☑ Burial 2 ☐ C 4 ☐ Donation 5 ☐	remation 3 🗆 F		cemetery	, cremator	y or other place Cemete		Sept. 201	27 I				Maryland
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		21. Signature of Funeral	Service License	Hall	un	22. Na	ne and Addres	-	old	lling	s Fu sade	neral	Home	e, P.A. 122
	hysician/	8 6	Immediate Cause (Final disease or condition	ure. List only one	e cause on each line	the death. Do no		mode of dying						Aş İn	oproximate terval Between nset and Death
	Medical Examiner		resulting in death)	_ (Due to (or as a	consequence of):								P40
	cate be executed physician and the burial-transit	al Examiner	Sequentially list condition of any, leading to immer cause. Enter Underlying Cause (Disease or iinjur that initiated events resulting in death) Last	liate	Due to (or as a	consequence of	ERY		3€						YEARS
	death certifiche attending ed for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	hs?	3c. If yes, outcome of 1 Live Birth 12 4 Pregnant at 9 Unknown	2 Fetal death		opic pregnanc er (specify)	у				23d. Date of Month	delivery Da	y Year
ls, P.O.	requires that the been signed by the should be detach		Part II. Other significan	t conditions con	tributing to death bu	ut not resulting in	the under	ying cause glv	en in Part I.						ause of death?
ပ္ပ	e law e has ge 2	Completed									24a. Was a autop perfor	sy med?	prior t death	o compl	findings available letion of cause of
<u>I</u>	Physician: The this certificate al director, pag	Be	25. Was case referred to examiner? 1 Yes 2 No	Tu.	ospital:		<u></u>	Othe	r:	(Check only			_		
ot <	ng Physter this	te: To	27. Manner of Death		1 Ninpatie 28a. Date of injur (Month, Day,			28c. Injury work	4 ∐ Nurs		5 Resid		Other (Sp occurred	ecify)	
ion	ttendir death. tor: Af ' the fu	Certificate:	2 Accident 3 Suicide 6	☐ Pending☐ Investigation☐ Could not be			N	1 0	Yes 2 🗆 N	-					
Ĭ	tal or A rs after al Direc ed in by		4 Homicide	determined	28e. Place of Injurbuilding, etc.	(Specify)	n, sireet, ie	ctory, office			City or Tow		Number or F	Hurai Ho	ute Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director. After this certificate completed filled in by the funeral director, pa	Medical	(Check 2 🗆 🖡	Medical Examine	cian: To the best of refer. On the basis of ex Practioner: To the b	amination and/or	investigatio	n, in my opinio	n, death occ	curred at the	time, date ar	nd place.	and due to th	e cause	s) and manner stated.
	To t with To t		29b. Signature and title of	of certifier	roughour)	МР		29c. License	number	*			e signed (Mo		Year)
			30. Name and address o	f person who co	mpleted cause of de	ath (Item 23a) (Ty		· · · · · · · · · · · · · · · · · · ·			•	_			
	Stat	е	31. Date filed (Month Da	10 305E 6	32. Pegistra		HOZP	TAL DA	ANE'	C.CED.	BURK	IL?	WOS	1161	- 2803

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Mabel Burk 7'126 A M September 75010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Glen Burnie 203 Somerset Bay Dr. Apt. 103 . Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Jan. 25, 1923 1 □ M 2XX F Days Hours Min. 216-16-9581 Director 87 Marviand Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If feem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 ☐ Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 203 Somerset Bay Dr. Apt. 103 21061 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes XX No
If Yes, Give
Year or Dates. Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes XX No Specify Specify: White Completed 3XXWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Seconday (0-12) College (1-4 or 5+) ll yrs. Board of Education N/A Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry George Bolander Marie Matilda Ochse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Somerset Bay Dr. Apt. 103 Glen Burnie, Md.21061 Constance J. Burk (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley M.G. 20a. Method of Disposition 20c. Location - City or Town, State Date A Burial 2 Cremation 3 Removal from State 7-27-2010 Baltimore, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility}l Home Lassahn Funeral Home _7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the discrese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final END-Stage Alghimers Dements a Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 No ဥ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar 29b. Signature and title of certifier

nsRajapamem.D

N.S. Rajapakse, M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 2 4 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

2835

D0057465

Smith Av. 5.703 - Baltimore, MD. 21209

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month, Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 5544 Oakland Road Baltimore 8. Date of Birth (Month, Day, Year) Dec. 18,1922 9. Birthplace (State or Foreign Country)
Maryland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Min. 1 **X** M 2 □ F Hours Yrs. Director 215-18-7594 87 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director MDBaltimore Baltimore 1 ☐ Yes 2 🄀 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21227 USA 5544 Oakland Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces 1 Never Married 2X Married 2 No þ Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) B & O Railroad 12 Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henrietta Helena Trebess Walter Henry Braun Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road Baltimore MD 21227 Pearlie C. Braun-wife 5544 Oakland 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Sept.22.2010 Baltimore MD Loudon Park 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc ral Service Licens 1328 Sulphur Spring Road, Arbutus MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ARKINSONS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death signed by the a Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b lirector, page 2 s autopsy performed?

Yes 2 No death? 1 Yes 2 No after death.

Director: After this certific d in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 ☐ Yes 2 XNo ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work?
1 Yes 2 No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier 🙀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one and title of certifier

State Registrar 29b. Signature

e and address of person who completed cause of death (Item 23a) (Type

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sept. 2010 8:30 P M Alva Lovola Bevard Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital/Seasons Hospice Baltimore Randallstown Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country Maryland 1 - M 2 X F Days July 31, 1912 **Director** 218-14-7846 98 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10c. City. Town or Location Examiner must be notified at 10d. Inside City Limits Director Catonsville 1 Yes 2 No MD Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21228 446 Kent Ave 11. Marital Status 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify. Specify: Completed 3 🕅 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the 12 Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Boyle Charles Littel1 Redifer Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 01d Fort Road. Winchester, Virginia 22601 Patricia a. Pilong-niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Sept.21,2010 Woodlawn MD 22. Name and Address of Facility Ambrose Funeral Home Inc Signature of Funeral Service Licensee 328 Sulphur Spring Road Arbutus MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Opet and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) elineus Pnysician/ Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ► No Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 4 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 N 2 No 1 Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 Tyes 2 🛂 No 1 - Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) Natural
Accident
Suici 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 037513 30. Name and address of person who completed car of death (Item 23a) (Type, Print) MO **2835** 31. Date filed (Month, Day, Year) egistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SANKS Physician/ AMES SEPT 20110 7:05A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yes June 24, Funeral Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1**火**□ M 2 □ F Days Hours Min. Country) Virginia 76 Yrs. Director 578-42-7672 1934 Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shouny or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7304 Silent Bird Court 21046 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married 1X Yes If Yes, Give 2 🗌 No Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify. Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ 12th Lithographer Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hall James Banks Virginia Blanche 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other to Patricia A. Banks/ Wife Columbia, MD 7304 Silent Bird Court, 21046 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/23/2010 West Arundel Crem. Odenton, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral HOme, M01103 313 Talbott Avenue, Laurel, 20707 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition and the cause)

ATHER SCHEROTIC ARDIOVASCULAR resulting in death) Onset and Death DISERS enysician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Yes 2 No 9 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by EUCO CHTOSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown STEDPOROSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy IABETES MELLETUS 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🔲 Yes Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Director / 6 Could not be Suicide within 24 hours after de To the Funeral Directo completed fil ed in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Grafflying Nursa Preficience To the basis of my included a state of the cause (s) and manner stated. 29a. Certifier (Check Gertifying Nurse Prectionen To the best of my knowledge, 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D28695 21 elleen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar ASNEEM

31. Date filed (Month, Day, Year)

SMITH

2835

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September Day 23, 2010 John William Boswell, Sr. 23:55 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery General Hospital Olney Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth . Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 1272571931 Washington, DC Director 213-30-6431 78 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 😾 No MD Silver Spring Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20905 2410 Briggs Chaney Road U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? 1XXXXs 2 \(\text{D}\) No \(\text{1949}\) þ 1 Never Married 2XXMarried Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: "natural" 3 Divorced 4 Divorced Completed 1970 White Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. The Man Elementary/Seconday (0-12) College (1-4 or 5+) Grade 12 Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George E. Boswell Regina Marsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen S. Boswell 2410 Briggs Chaney Road Silver Spring, Maryland spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crem. 9/26/10 Odenton, Mayrland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral home, P.A. M00770 313 Talbott Avenue Laurel 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and D, ath Immediate Cause (Final Saposis Fnysician/ disease or condition MONTH Medical resulting in death) Due to (or as a consequence of): **Examiner** Lymphoma Diffuse B-Call Large Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Diabetas 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Coronary autopsy performed' after death.

Director: After this certificate 2 No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗹 No 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of eerti

State Registrar

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31. Date filed (Month, Day, Year)

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Olandwood Ct.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3418

32. Registrar's Signature

23,2010

20832

MD

Oluay

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 04:50 A Patricia Ann Bailey September Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday **Funeral** (Month, Day, Year) 0ril 10,1948 1 🗆 M 2 🏋 F Hours Min. Nebraska Director 213-54-6769 62 Usual Residence of Decedent or 28a-f shov and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No Prince George College Park Maryland| 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20740 United States 5810 Bucknell Terrace 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Completed by 1 🕅 Never Married 2 🗆 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Vending Machines Assembly Line Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mary Breda Wynne William Andrew Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David A. Bailey/Brother Clark Station Road, Severn, Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arundel Crematory 09-22-2010 Odenton, Maryland 21. Signature of Funeral Service Licensee ²² Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road Odenton, Maryland 21113 Well Elover M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on ea h lin. de of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death ed by the a 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No Completed 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Ă Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t 5 Pending neral Director: Af within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 1 ☐ Yes 2 ☐ No Investigation Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Detrifying Prystation: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifler

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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

31. Date filed (Month, Day, Year)

29c. License numbe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State
 Registrar Certificate of Death Reg. No. t. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER 14 2010 BOSTICK 4:03 P M ALBERT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 23 1924 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F NEW ORLEANS Director 438-42-1589 86 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD MONTGOMERY SILVER SPRING Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20910 USA 8502 16TH STREET # 317 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give "natural", Specify: BLACK 3 ☑ Widowed 4 □ Divorced Year or Dates 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. If item 27 is marked other than "natur other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) FEDERAL GOVERNMENT OFFSET PRESSMAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
REBECCA JOSEPH ၉ HERBERT BOSTICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11031 LAKE FOREST BLVD NEW ORLEANS, LA 70127 WILLIAM T. BOSTICK/SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important; If ite
any injury or ot Date Page 1 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 11/8/2010 ARLINGTON, VIRGINIA ARLINGTON CEMETERY ture of Funeral Service Licenses . Sia 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ CARDIOPULMONARY ARREST disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner HYPOXIA Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit PNEUMONIA that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performe Yes 2 X No 2X No 1 Tes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 1 \(\simeg\) Yes Hospital: 2**X** No Other: |@ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 5 Pending ours after death.

neral Director: A
filled in by the fu 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral Completed filled Medical 1 🔯 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) SEPTEMBER 16, 2010 D64100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMITHA BHIKKAJI M.D. 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND 20910 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Do State of Maryland / Do State of Maryland / Do State of Maryland / Do State of Maryland / Do	epartment of Health and Cartificate of Death	Mental Hygie	2010 29991
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	/Medic		Kylee Kathleen Betz 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	23 2010 2005 M
	Examin	er	Greater Baltimore Medical Center			Baltimore
	Eunaval		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		8. Date of Birth	9 Birthplace (State or Foreign
	Funeral Director		1 □ M 2 🗹 F Y	Months Days Hours Mir		ar) Country)
			Usual Residence of Decedent		0 04/23/20	DIO MARYLAND
	ylanc now		10a. State 10b. County 10c. City, Town of	or Location		10d. Inside City Limits
	Mar a-f st	호	MD Baltim	iore		1 □Yes 2 □ No
	r 28g	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	3a o		5710 Kenwood Avenue	21206		USA
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be invitfied at	Funeral		13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian,
9	or ite		1 Never Married 2 Married 1 ☐ Yes 2 No		to Fican, etc.)	Black, White, etc.
21215-0036	ours a	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 □Yes 2 ⊠ No Specify:		Specify: White
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Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I've My clical Fyan inter ust by myllified at other traumatic event, I've My clical Fyan inter ust by myllified at	10 1	Anthony	Betz Erica	С.	Williams
a	2 sho n and is ma rauma		19a. Informant's Name/Relationship (Type. Print)	Mailing Address (Street and Number or I	Rural Route Number, Ci	ty or Town, State, Zip Code)
	s 1 and 2 of Health item 27 other tra		Erica C. Williams/Mother 57	10 Kenwood Ave; Ba	ltimore, MI	21206
<u>S</u>	of He			Disposition (Name of crematory or other place)	Date 20c	Location - City or Town, State
Ĕ	Page nent int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ♣ Other (Specify) in State			
Baltimore,	permit. Pages 1 Department of I Important: If ite any injury or ot once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	·	
m	9 9 E E 8		Ronald S. Wade, Director	State Anatomy Boar	d, 655 W.	Baltimore St 21201
			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between
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Records,	s bee	lete			24a. Was an	24b. Were autopsy findings available
	: The law cate has b page 2 sl	Completed			autopsy performed	
VItal	70 0		25. Was case referred to medical	26 Place of D	ath (Check only one)	KNo 1 □ Yes 2 □ No
	Physician: r this certific ral director,	o Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outs	Other		e 6 ☐ Other (Specify)
ō	Phy er this eral c	1: To	27. Manner of Death 28a. Date of Injury 28b. Til	me of 28c. Injury at	28d. Describe how in	
0	fun Affe	Ē	1 Matural 5 □ Pending (Month, Day, Year) Inj 2 □ Accident investigation	ury Work? M 1 ☐ Yes 2 ☐ No		
<u>s</u>	Atter dea ctor	fice	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm	n, street, factory, office	28f. Location (Stree	t and Number or Rural Route Number,
UIVISION	after On the	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, S	tate)
	spita nours neral / fille		29a. Certifier 12 Certifying Physician: To the best of my knowledge,			
	To the Hospital or Attending Physician: within 24 hours after dear To the Funeral Director. After this certific completely filled in by the funeral director,	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.	or investigation, in my opinion, death oc	curred at the time, date	and place, and due to the cause(s)
	To th Withir Somp	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
				D33938		1-23-10
			30. Name and address of person who completed cause of death (Item 23a) (T			
			Issam Daya, M.D.; 22 West Road -		oro Mr 21	204
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signaritie	A 3	ne, m Zl	AV7
	Registr	-	31. Date filed (Month, Day, Year) SEP 2 4 2010 34. Registrar's Signature	Tarres .		

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		1	_ State	State of Marylan		artment <i>tificate</i>				iene leg. N2 0 0	29991		
			1. Decedent's Name (First, Middle, Last)		001	imouto	0. 200		2. Date of Deat	th	3. Time of Death		
	Physicia Medic		Raymond F	. Burgess					Septemb	per 22 20	10 11:00p ^M		
-	Examin		4a. Facility Name (if not institution, give str 7102 Carmae Road	eet and number)			own, or Loca Sykes	tion of Death		4c. County of Death Carroll			
	Funeral Director		5. Social Security Number 6. Sex 1 🕅	M 2 \square F 7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Months		Inder 24 Hrs. Jurs Min.	8. Date of Birth	Year 1937 Ma	Birthplace (State or Foreign Country) aryland		
	d t t		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Lo	cation					10d. Inside City Limits		
	larylan 3a-f sh ified a	ecto	Maryland Carroll	1007.01	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		esvil:	le			1 ☐ Yes 2 🎇 No		
	ith the N 23a or 28 st be not	Funeral Director	10e. Street and Number 7102 Carmae Road			10f. Zip (21784			10g. Citizen of What US			
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.			2. Was Decedent Ever in U.S. Armed Forces? 196 1 X Yes 2 No 196 If Yes, Give Year or Dates.	50-	Was Decede If Yes, specif	y Cuban, Me	exican, Puerto	ecify Yes or No- Rican, etc.)	Black, Wh	merican Indian, nite, etc. Vhite		
21215-0036	thin 72 hours sne. than "natur ne Medical I	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		(Give	O NOT use i	done during	g most of work	ing	16b. Kind of Busines	ss Industry		
land 2	l be filed wi fental Hygie rked other tic event, th	0	17. Father's Name (First, Middle, Last) Russell Wilson	Burgess			18.		e (First, Middle, l lie Jame	Maiden Surname) S			
Maryland	12 should lith and ∿ 27 is ma r trauma		19a. Informant's Name/Relationship (Type Christian C. Fishe		19b. Maili 7102	ng Address Carma	(Street and Nace Roa	lumber or Rura d Syke	al Route Number esville,	City or Town, State, MD 21784	Zip Code)		
nore,	ige 1 and nt of Hee t: If item		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		Place of Disponentery, cre-	matory or oti	her place)	i	Date 94/2010	20c. Location - City Sykesvil			
Baltimore,	permit. Pa Departme Importan any injuny once.		21. Signature of Funeral Sandce Licenses								(410-795-1400)		
	M		23a. Part 1. Enter the disease, or complications, or heart failure. List only one		h. Do not ent	ter the mode	of dying, su	ch as cardiac	or respiratory arr		Approximate Interval Between		
4	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq		Al AR	PRIA	1 dose	cone		Onset and Death		
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Days to (or as a conseq	uence offic								
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90	te be e nysicia he buri	dical											
Box 68760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	☐ Ectopic p☐ Other (sp				23d. Date of Month	delivery Day Year		
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of Vi	Phys this ral di	ite: To	1 Ves 2 No 27. Manner Death 1 1 Natural 5 Pending	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of injury	of 2	Bc. Injury at work?			dence 6 Other (S) now injury occurred	oecify)		
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the fune	Medical Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, st	M treet, factory		2 🗌 No	28f. Location (S City or Tow		Rural Route Number,		
Ω	Hospital 24 hours : Funeral I eted filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	To the within To the comple	Σ	only one) 3 L Certifying Nurse 29b. Signature and title of certifier		.,	29c	. License nu	mber D3 i	.660	29d. Date signed (Me	onth, Day, Year)		
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0			30. Name and address of person who co	17 1	m 23a) (Type,			M 1~87	er ma	by land	2(15)		
	Sta	ate	31. Date filed (Month, Day, Year)	4 2010 Registrar's Signa	ature	1. 40	ares						

DHMH 17 Rev 7/2009

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Amend #8 per Fb g907 9/24/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 4a. Facility Name (If not institution, give street and number) 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner enter 5. Social Security Number Medic Itimo Homore 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year 2010 Days Min. Months 1**5**€M 2□ F Hours NIA Director 09 54 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Completed by Funeral Director MD 1 XYes 2 ☐ No Baltimore (Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3319BIngelsi 225 LSA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, I'm M. Elementary/Secondary (0-12) College (1-4or 5+) NA NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ess101 TASIA ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bivins Tasia mother 3319 B Baltimore MO 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician reterm Previa /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): P.O. Box 68760. the attending physician Physician/Medical the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 D Ectopic pregnancy ū Month Day Year 5 ☐ Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. be Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown been (24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒No 24a Wasan this certificate has 2 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Lua

31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

ORIGINAL

M.D

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** BIVINS 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE Cui MESSICE BAUTMORE MERCY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
 Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Year) Months Days Hours 1 □ M 2 💢 F Director an Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Director MD timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3319 2121 Funeral tue 11. Marital Status
1 Never Married 2 Married Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NA NIA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bruins MKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore lasia Bivin mother 20b. Place of Disposition (Name of cemetery, crematory or other place) MO 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State -ASLTON FUNERAL HOME ROAD 21200 Baltimore 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sc WILLOW oad 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or rest atory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 417 WEERS Permanere **Physician** DELILEVAL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to initial data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) as the burial Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year detached for 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1□ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Mannet of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? funeral 28d. Describe how injury occurred Certification: 1niury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier id Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 BALTINOZE MD GREENE 31. Date filed (Month, Day, Year) State Registrar

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State of Maryland / Department of Health and Montal Usaira

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State of Maryland / Department of Health and Mental Hy	giene

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21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medical	3 [Raymond				r.						yce		-				
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month - 10-2010 ncugn Daya Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death JOSHINGTON ADVENTIST lakoma av Wont 60mery If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. South Carolina Director Usual Residence of Decedent 28a-f shov 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director **IEMPLE** MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20 ameson 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married ģ ☐ Yes 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Specify: Black "natural", 3 Widowed 4 Divorced Completed Year or Dates any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

KEY PUNCH OPERATOR 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " ATHOLIC Elementary/Seconday (0-12) College (1-4 or 5+) ·TH Oniversity Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) mma Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ameson St., 1 emple CONGHIE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Beltsville, MI 4 Donation 5 Other (Specify) 70 H St. NE. Wash. DC. 120002 Signature of Funeral Service Licensee emru HENNY FUNERAL W01118 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ ACUTE MYO CARDIAL disease or condition resulting in death) INFARCTION Medical Due to (or as a consequence of): Examiner CORON AMY Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen RENAL FAILURE Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? 1 Yes 2 No 24 hours after death.

Funeral Director; After this certificated filled in by the funeral director, I 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No J. 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending 1 Yes Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Fune completed fi Certifying Prinstrain. To the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D40324 SEPTEMBER 10, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 CARROLL AUDNUE, TAKOMA PARK, MARYLAND TERRY JODRIE, MD, FACEP 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

SEP 24 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) sept.21,2010 Physician/ 1:59 James AM Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 10 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F 212-56-7339 59 Director N.C Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County Director MD n/a event, the Medical Examiner must be notified Baltimore 1 🖳 Yes 2 🗌 No 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Number 23a Funeral 1704 N. Castle St. 21213 USA "natural", or items should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) truck Driver Baltimore City 1.2 th8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ James A. Brown Nettie Fowlkes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra Rashida Teombe (daughter) 1306 Ballard Way Balto, Md. 21224 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State onation 5 Other (Specify) Mount Cremator Balto, Md. ture of Funeral Service Licensee 22 Name and Address of Facility Callvin B. Scruggs Funeral Home 2 E Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) IVET Medical Due to (or as a consequence of): now **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Second at time of death 5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed Metabolic Eucephalopatuy 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed?

Yes 2 No has death? 2 No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending work?
1 Yes 2 No Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical K certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature **L**title of certifier DOO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

State Registrar J DHMH 17 Rev 1/2001 29b. Signature and title of certifier

KUBO

the completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

29c. License number

			1 - For State Registrar	State of M	aryland / Depa	artment of rtificate of			giene 0 1 0	29998
ı	Physici /Medi		1. Decedent's Name (First, Middle,	Last)	CATHE	PR		2. Date of De Month	Day Yea	
	Examir		4a. Facility Name (If not institution, SWICK 5. Social Security Number	Muzt:	L-CAPE e (In yrs. last birthday)	4b. City, Town, A If Under 1 Yea	or Location of De	ath ORE	BAUTT	MORECITY
	Director		220-22-1938 Usual Residence of Decedent	1 25 M 2□ F	78 Yrs.	Months Days	s Hours Mi	75. 8. Date of Bir (Month, Da 3/28/	1932	Birthplace (State or Foreign Country) MD
	e Marylan	ctor	MD 10b. County Ceci.	L	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with th	al Director	P.O. Box 223			10f. Zip Code 21904			10g. Citizen of What USA	Country?
9600	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or teme 23e or 28e-f show event, it a Medical Examinar must be rotified at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ☑ Øivorced	12. Was Decedent Armed Forces? d 1 Yes 2 If Yes, Give Year or Dates:	yo I	Was Decedent of f Yes, specify Cu	ban, Mexican, Pue	(Specify Yes or No arto Rican, etc.)	14. Race - Ar Black, W Specify:W	
21215-0036	c * 3	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	Education grade completed) College (1-4or 5	(Give	lent's Usual Occu kind of work done DO NOT use retire Master	e during most of w ed)	orking	16b. Kind of Busines U.S.P.S.	
Maryland	should be filed within and Mental Hygiene. marked other than umailc event, it a Mi	To Be (17. Father's Name (First, Middle, La Robert Leslie				18. Mother's N Mary I		Maiden Sumame)	
	1 and 2 and 4 and		19a. Informant's Name/Relationship Michael Cather 20a. Method of Disposition		5847	Richar	dson Me	ews Sq.	Balto, M	ID 21227
Baltimore,	Pages nent of ant: If it		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)	20b. Place of Dispo	ake Cre	em.	ot. 22, 2010	Beltsvil	le, MD
Ba	permit. Departimonts any inji		23a. Part1. Endy the disease, or or	e Retter) 8	717 Gre	en Past	ures Dr	. Balto,	hrmann P.A MD 21286
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	a consequence of):	3STR	ICTUE (OLLMON	ARY DISASE	Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and id for use as the burial-transit	ical Examiner	aw, leaving to aminodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	a consequence of):					
P.O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date of d Month	lelivery Day Year
	sign d be	ρ	Part II. Other significant conditions DOMONT		It not resulting in the un	derlying cause gi	ven in Part I.			to the cause of death?
Vital Records,		Completed	TYPE Z	DIABET	es Mec	LITU	S	24a. Was a autop perfor	sv prior to	
f Vit	Physician: The this certificate had director, page	To Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatie	nt 2 EP/Outpatient	3□ DOA Ot	her	eath (Check only or	ne) lence 6 ⊡Other (Sp	necity)
Division of	Jing I		27. Manner of Death 1		Year) 28b. Time of Injury	28c. Inju Wo M 1			ow injury occurred	No.
Divi	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not determine	building, etc				City or Tow		
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	Medical	one)	Physician: To the best of aminar: On the basis of and manner sta	examination and/or inv	occurred at the ti estigation, in my	ime, date and place opinion, death occ	e, and due to the curred at the time, o	ause(s) and manner a date and place, and di	as stated. ue to the cause(s)
	Twit To no	-	29b. Signature and title of certifier	1. All	no mo	29c. Licen	6360	ئل	29d. Date signed (Moi	21,2010
			30. Name and address of person wh 31. Date filed (Month, Day, Year)	m 700	DW. 40	th St	. Bal	to., M	10 dl	211
k	Stat Registra		SEP 2 4 2	010 June	r's Signature	ald				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 21 per dvr., gd Penartment of Health and Mental Hygiene (Certificate of Death 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 Month Betty Jean Carter August 20, \mathbf{a}^{M} 6:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9 West Cumberland Street Clear Springs Washington Funeral Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) MD 1 🗌 M 2 🗶 Days Hours 214-54-2320 0870671949 Director 61 Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified MD Washington Clear Spring 1 🗆 Yes 2 🔀 No 10f. Zip Code 10g. Citizen of What Country? Funeral 9 W. Cumberlans Street 21722 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 3 X Widowed 4 ☐ Divorced 1 ☐ Yes 2 TNo Specify: Completed Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry unk (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11 Cashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked c Melvin Charles 01den Edith Marie Grams of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 W. Cumberland Street; Clear Spring, MD 21722 Robin Whitmore - daughter Baltimore, 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 21. Signature of Funeral Service Licensee per DVR 22. Name and Address of Facility State Anatomy Board Ronald S. Wade, Director 655 W. Baltimore, Street; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Recurrent Pyelonephitis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner bilatera ureteroileal amatomic Chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury 4-00 Examine Due to (or as a consequence of) sician and burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant a 9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe Division of Vital Records, or Attending Physician: The law requires poorly controlled type 2 diabetes 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed gravis gastroparesis 24b. Were autopsy findings available prior to completion of cause of death? myasthenia 24a. Was an has autopsy yes 2 No chanic back pain, chronic abdominal pain 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at After 1 28d. Describe how injury occurred work?
1 Yes 2 No Natural 5 Pending injury Accident Investigation within 24 hours after deal To the Funeral Director: 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 00050882 9/17/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) real fataling hung M.O William sport, MD 21795

DHMH 17 Rev 7/2009

State Registrar gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 30000 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Chambarlis Month Day 5: 40 P Medical Septembe 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown <u>Baltimore</u> 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)

DA 1 ★ M 2 □ F 216-18-0853 Months Hours Min June 2/2 1 924 **Director** 86 PA Usual Residence of Decedent 28a-f shov 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Essex 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral and 2 should be filed within 72 hours after death with the Health and Mental Hygiene. 504 Georgia Avenue 21221 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ¥Yes 2 ☐ No Yes, Give 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Work 12th Beth Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Chambarlis Katherine Karsola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
504 Georgia Avenue Baltimore MD 21221 if Health a Carolyn Sturgill /wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 9/25/10 Baltimore MD 21. Signature of Funeral Service License 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, encomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Immediate Cause (Final Ph sician/ Onset and Death END-Stage (UPP disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy Pregnant at time of death Other (specify) Month g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>چ</u> 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2. autopsy performed Yes 2 🗸 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 - Nursing Home 5 - Residence 6 Other (Specify) ၉ 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Mangrer of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? _1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number MSKajapalniM.D DUUS7 465 9/22/10

/ DHMH 17 Rev 7/2009

State

Registrar

2835 Smim Av. 5-203.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's ignatu

N. S. Rajapakse, M.D.

SEP 24 2010

31. Date filed (Month, Day, Year)